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## Communications.

### MEDICAL SYMBOLISM.

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Fig. 1.

It has been well said by some one that things are not always what they seem. In the interesting and extensive field of symbolic knowledge this is, of all places, most emphatically true. Here is a figure (No. 2). Ask an uninitiated person to look at it and state what he sees, and his reply will likely be, "A snake partly coiled, resting on a pedestal." That is, indeed, simply what it is; but to the initiated it is representative of another and far different thing. Before such a figure, many a human being, diseased and suffering, has prostrated himself and offered up supplications for relief; to generations of the people of the Eternal City, and regions far from, as well as near to, the famous Tiber, it appeared a god, the great god of "the divine art." It is a symbol of medicine.

Fig. 2.

In my incursions into the field of symbolic knowledge, I have made notes, among which are some pertaining to medicine. But little appearing to be generally known about medical symbolism, it has occurred to the Editor of the Reporter, as well as myself, that an article on the subject would be read with pleasure and profit by many. I do not propose to treat the matter, however, either systematically or exhaustively; such treatment of it would require much space; but I will endeavor, in a somewhat desultory way, to go into it sufficiently to instruct a little, as well as show that it is an interesting study.

Now, to begin with, I deem it proper to define a few terms, the meaning of which should be understood, or confusion of ideas will likely be experienced. In giving the article the title of "Medical Symbolism," I have intended the word symbolism to be taken in its widest sense; I desire it to be taken as of much the same signification as emblem is popularly; that is, a figure having a different meaning besides the visible one—a meaning which to be perceived calls for exercise of the imagination. Mackenzie* and other authorities, however, hold the word emblem to be properly applicable only to a figure of two or more parts. In a device there is a motto which the picture portrays more or less clearly. Allegory is almost synonymous with emblem, in its restricted sense, and is used only in reference to a composite figure, the chief consideration in which is the beauty of form. In an allegorical figure, or composition,

*Royal Masonic Cyclopædia.

the elements of it are attributes, some of which are essential and some conventional. Essential attributes alone are, strictly speaking, symbols. Thus in a representation of the Goddess of Liberty, the cap is not a symbol, it is a conventional attribute. If a poppy be taken to represent sleep, it is a symbol. In Fairholt's work* and others, the serpent in medicine is said not to be a symbol; but this is not true, if it be taken to represent the god of medicine, which was done, as I have intimated above, by the Romans. Evidently, if the word symbol were taken as of this narrow meaning, there are very few general medical symbols. In taking it, as I do in this article, to be of much the same meaning as emblem, a word applicable to any mystic figure or any kind of attribute, I do no more than Fairholt says it would be wise to always do. Any figure, then, having another besides its ordinary signification, may be regarded as a symbol.

I have said that the god of medicine was represented and worshipped by the Romans in the form of a snake or serpent; this curious creature was regarded by them as being, to all intents and purposes, Æsculapius himself. As is very generally known, medicine did not receive a great deal of attention, by that extraordinary people, until a comparatively late date. It was in the year 293 before the Christian era that a move was made to introduce the worship of the god of medicine. This was ordered by the Sibylline Books, in order to cut short a great pestilence. How this was done we are graphically told by Ovid.† It is a remarkable story and must be known, if one would understand, according to some, the reason why the god was given the serpentine form, the serpent being generally regarded as only an attribute of him at his chief residence, the great Æsclepion or Temple or Health at Epidaurus, his birthplace. A commission on sailing around to the Grecian city, to bring home with them the god, were led for some reason or other to believe that a snake, or rather viper, which entered the ship, was the divine personage they were sent for. On returning with this precious being on board, it, or rather he, took up his abode on an island‡ in the Tiber, where he was subsequently worshiped, a great temple being erected for him.

What species of serpent it was which played the important part just indicated, is an interesting matter. In Pliny's work it is said: "The Æsculapian snake was first brought to Rome from Epidaurus, but at the present day it is very commonly reared in our houses even, so much so, indeed, that if the breed were not kept down, by the frequent conflagrations, it would be impossible to make head agains the rapid increase of them." From this statement one may justly infer that it was not a decidedly venomous snake. A species of viper still common in Italy is believed to be the identical reptile. It reaches a length of about two feet. It has been described under the name of Columber Æsculapii. It is spoken of under this name in Cuvier's great work.* That learned naturalist says that it is more bulky and not so long as the col. elaphsas, or four-striped adder, and continues, "It is brown above; strawy yellow beneath and on the sides; and the scales of the back are nearly smooth." After the brief description he adds, "It is that which the ancients have represented in their statues of Æsculapius; and it is probable that the serpent of Epidaurus was of this species. N. B.—The col. æsculapii of Linnæus is a totally different species, and belongs to America." The columber æsculapii, Sh. is closely related, if not identical with the viper communis, or pelias berus, of which Figuier says,† "It is not improbable that it is the *echis* of Aristotle and the *vipera* of Virgil, as it is the *manaso* of the Italians, the *adder* of the country people of England and Scotland, and the *vipère* of France."

It, of course, follows from what has just been said that the adder spoken of is the serpent which should always be shown in medical symbolism.

I would ask the reader to turn with me now to the shore of the Saronic bay, to the Peloponnesian city Epidaurus, a place dearer than Salerno, or even Cos, to every lover of the annals, historical and legendary, of the healing art. There is but little about it at present to indicate its ancient glory.‡ But for the ruins in the vicinity and the imperishable records we have of them, one would

*A Dictionary of Terms of Art.

†Metamorphoses, b. xv.

‡In his "Historia Naturalis," Pliny states that "Temples of Health were placed by the Romans without the city, and afterwards on an island." This was customary with the Greeks, too. They did not relish much more than the Romans having such institutions in their midst. The Epidaurean Oracle was without the town, and other notable ones, such as Rhodes, Cnidus and Cos, were, as the names indicate, on islands of comparatively small size. I need hardly say that there are excellent sanitary reasons for placing hospitals in the country, and especially on insular sites.

*Op. cit.

†Le Règne Animal.

‡Reptiles and Birds.

§Vide Leake's "Travels in the Morea."

not care to linger long about the scraggy village. It is chiefly the pages of Pausanias,* that observing and inquisitive old Grecian traveller, which tell the physician most of what is interesting to him about the place. On the plain five miles or so west of the town, was the great seat of worship of Æsculapins, the primary and perhaps greatest temple of the god of medicine, to which crowds came for ages from all parts of Greece. The Epidaurean oracle is gone; it is silent as the vanished millions who sought the means of health and life from it; but an impress of it is still felt, and will last forevermore. To this long-renowned sanatory retreat one must turn who wishes to become acquainted with the most important of medical symbols.

The statue of Æsculapius, at Epidaurus, was a remarkable piece of work, by Thrasymedes. Time has put it, with many another treasure, out of sight. It consisted of ivory and gold. When Pausanias visited the place, which was in the second century of our era, he drew from the inhabitants an interesting account of it. The figure was manly and handsome, Zeus-like. It was seated on a throne. One hand rested on the head of a serpent, and in the other was a staff. By the side of the god, lay a dog. In this, one has a very expressive allegorical representation of the healing art.

The statues of Æsculapius were, for the most part, ideal, and as might consequently be expected, varied greatly in their details; but there was a serpent connected with each of them, in one way or another. In some the great healer is represented as a bearded old man. The beard was occasionally absent, which I think was wise; for the conscientious physician should have nothing about him, which he can dispense with, which would serve to spread disease. It is said that Dionysius, king of Sicily, on conquering the Morea, ordered the golden beard to be taken off the Epidaurean god, for the peculiar reason that "it was unbecoming and unjust for the son to have a beard when the father [Apollo] had none." In the famous colossal head now and since 1866 in the British Museum, which seems to be that of a splendidly developed man in his prime (what it should be as that of the image of an ideal physician), the beard is of but moderate length, and is waved like the somewhat long hair. This noble remnant of Greek art, one of the finest in the museum, which is saying a great deal, Nichols† regards "as scarcely less remarkable" than the celebrated "Venus of Milo" in the Louvre, both of which were found, the former in 1828, in the island of Melos, and came originally, it is surmised, from Cnidus, the seat of an æsclepion, with those of Rhodes and Cos, of great renown in the fifth century before the Christian era.

In the left hand of some figures of the god there is a scroll—a very appropriate symbol—and in connection with not a few representations of him, a little child, or dwarf, wrapped in a mantle, stood by his side. Occasionally a cock, or crow, or goat, was given.

As I have said, a serpent was always shown in the representations of Æsculapius. It is, in some cases, coiled around a post,* by the side of which the god stands, and in some it is coiled around a staff, which he holds in his hand. The staff is sometimes given as knotty.

In this connection I may speak specially about the staff and snake, as it is usually designated, of the god, about which there seems to be considerable misconception and confusion prevailing. As I have stated, the serpent is only sometimes represented as coiled around the staff, an attribute, indeed, which is not always present. Now, when the staff is given bearing a serpent, it must not be regarded as a magic wand, for Æsculapius had nothing of the kind. A very different personage, Mercury, had a wand, or rather caduceus, which, strange to say, is taken by many to be a symbol of medicine. That is, Mercury's caduceus, which is not of medical import at all, is accorded to Æsculapius, who really had none. I repeat, there is no such a thing as an Æsculapian wand, if wand be taken as meaning a rod or staff possessed of mysterious power. A staff with a serpent twined around it, however, is an expressive medical symbol. It may properly be regarded as an emblem of Æsculapius. I give a good example in Fig. 3, copied from a plate in De Wilde's rare old work.† The serpent may be taken as a symbol of the god, and the staff as one to indicate the perambulatory character of the physician's calling. Regarding the knots as expressive of difficulties in the art and practice of medicine is very fanciful, but not infrequently done.

Fig. 3.

I deem it not amiss to give a cut (Fig. 4), of the caduceus of Mercury, in the hope of better removing misapprehension in regard to it. It is

* Itinerary of Greece (Hellados Periegesis).

† Handybook of the British Museum, 1870. An excellent engraving of the head appears as the frontispiece.

* This, or even the staff, may be a remnant of tree-worship. Vide infra.

† Gemmæ Selectæ. Amsterdam, 1703.

given as shown, but not very correctly, on a seal used by the United States Marine Hospital Service.

FIG. 4.

It is an appropriate trade symbol, Mercury being the god of commerce as well as the messenger of the gods; but it is more especially a symbol of peace, the god being the great peace-maker. Traditional history relates that in his rambles one day, he saw two snakes fighting, and laying his wand, which was originally an olive branch, between them, was delighted to discover that it had the power of putting an end to the encounter. Hence the presence on the wand of the two serpents, which, of course, it would be wise to represent as belligerent. Mercury being an adept thief, was regarded as the god of rogues; from which fact taking his caduceus as a symbol of medicine is a left-hand sort of compliment to the physician, even if he is one who regards his profession chiefly as a trade. And this brings to mind a very truthful remark of Bacon*, namely, "If physic be a trade, it is the trade of all others the most exactly cut out for a rogue." Another function of Mercury, which I may mention, was to attend to dying persons, to unloose their souls and drive "them down the Stygian waves," as we are told by Virgil.† It is hardly a part of the physician's proper function, I submit, to do that.

How to account for the association of the serpent with the god of medicine is a trifle puzzling to many.‡ Saying that it is symbolic of prudence and renovation is not quite satisfactory, although it may be properly taken as of such import. "As wise as a serpent," is an everyday saying. Casting of the skin is said to be the basis of the idea of renovation or rejuvenescence. Taking it as expressive of the idea of convalescence is not out of the way, for it undergoes, every spring, a remarkable change from a state of lethargy to one of active life, under the strengthening rays of Apollo himself, as will be seen later, the original Grecian god of medicine. This notion is well portrayed in Mrs. Palliser's interesting work,‖ in the device of the Rinovati Academy.

The commonness of a tame, but somewhat venomous serpent, the adder already spoken of, about and in the Epidaurean Temple of Æsculapius, has been advanced as explaining the association of the reptile with medicine. This may have had something to do with it.

After referring to some strange curative virtues, attributed to vipers, Pliny* says: "Hence it is that the snake is consecrated to Æsculapius." Here is one of the examples given by the rather credulous old Roman: "It is a well-known fact that all injuries inflicted by serpents and those even of an otherwise incurable nature, it is an excellent remedy to apply the entrails of the serpent itself to the wound." The principle is evidently the same as that illustrated in applying a hair of the dog to cure the wound caused by the animal.

Still another reason for the association has sprung from the reputed power of the serpent to discover herbs of curative virtues. This is largely based on a traditional episode in the history of Æsculapius, which reminds one of the German story of the Snake Leaves, told by Grimm.† It seems that on one occasion while thinking what treatment to resort to in the case of one of his patients, Glaucus, a serpent appearing and twining itself around his staff, he killed it, whereupon another came, bearing in its mouth an herb with which it restored the dead one to life. The god used the same herb with similar effect on the human subject. The miraculous feature of this explanation puts it on a par with such as one would expect from the Indians, whose "medicine man," too, is apt to have a snake at hand, as he is also, I may say, to make himself bird-headed,‡ reminding one of the Egyptian Thoth, and others.

I am of the belief, however, that the remarkable association of the serpent with the god of healing must be largely explained in yet another way. There is good reason to hold that we have in it a remnant of serpent-worship, a wonderfully wide-spread cultus, still kept up by the Nagas (literally snakes) of India,‖ and others. Epidaurus was open to frequent communication with Egypt, where the serpent played a great religious role, being in different forms representative of good and evil. Says Sharpe in his excellent little

* Advancement of Learning.

† Æneid, b. iv.

‡ It is worth while to remark that, in his life of Cleomenes, Plutarch states that it was believed that after death evaporation of "the marrow" produces serpents, and that "the ancients knowing this doctrine, appropriated the serpent, rather than any other animal, to heroes."

‖ Historic Devices, Badges and War-cries.

* Op. cit.

† Household Tales.

‡ Vide engraving in "False Gods" by F. S. Dobbins.

‖ Says Dr. Birdwood, in his "Indian Arts": "The worship of the snake still survives everywhere in India, and at Nagpur was until very recently a public danger, from the manner in which the city was allowed to be overrun with cobras."

work,* "The venomous snakes and those that were not venomous were alike honored, the first as the gods of evil, and the second, as gods or rather goddesses of good." The serpent of good is always represented as prevailing. The creator of the world was given a serpentine form. The sect of Gnostics, called Ophitæ, taking the world to be evil, attributed its creation to the serpent of evil, Eve's acquaintance. Evil in the shape of disease might be expected to be overcome by the serpent of good.

(*To be continued.*)

## A RARE FORM OF RETINAL AFFECTION.

BY M. LANDESBERG, M. D.,
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Mooren† first drew the attention of the medical profession to a peculiar form of retinal affection, which he saw but in one instance during the long term of his ophthalmic practice, and of which no mention had been made before in the oculistic literature. This affection, which he calls "retinitis punctata albescens," was characterized by innumerable punctate, whitish spots, resembling crystals of choleasterine, which were spread over the whole retina. The communication of Mooren's unique case was very soon followed by the report of one similar case, made by Kuhnt, and of three others by Hirschberg, to which has lately been added one case by Swan M. Burnett. As a further contribution to the knowledge of this rare and highly interesting form of retinal affection, I beg leave to present the following three cases:

Case 1. Bookkeeper H., 53 years old, applied to me, August 26, 1877, on account of a dark spot in the centre of the visual field of his right eye, which has gradually developed during the last six weeks, greatly impairing vision. Examination showed:

*Right Eye.*—M=$\frac{1}{40}$. V=$\frac{15}{40}$. With the naked eye Jaeger 9, with convex 10 Jaeger 4. The visual field, measured at one foot distance from the perimeter, is of normal extent in its outlines, but shows in its centre a ring-shaped scotoma of sixteen lines in diameter. The color-perception within this scotoma is entirely abolished for red and green, and slightly impaired for blue. White is perceived as dirtyish-gray. Pupil and tension are normal. The optic disc is of pinkish color, with well-defined border and normally arranged vessels. The region between the optic disc and macula lutea is thickly studded with numerous, minute, yellowish-white points and dots, which appear in groups and isolated, leaving free the track of the vessels. On the inner border of the macula lutea there is a small, irregularly-shaped, whitish-glistening spot, and close to the latter a flat extravasation of blood. A somewhat larger extravasation of blood is situated below the inner border of the optic disc. The retinal tissue of this area is slightly veiled by a delicate diffuse opacity, and presents a dull-reddish hue. The faint exudation shades off into the adjacent retina, which altogether with the whole remaining surface shows absolutely normal condition. Only one inferior branch of the ophthalmic vein is slightly tortuous and hyperæmic. All blood-vessels can be followed up to their finest ramifications.

*Left Eye.*—Amaurosis. Refracting media transparent. Optic disc atrophic; blood-vessels very thin and totally obliterated towards the macula lutea. The region between the latter and the optic disc is occupied by numerous, minute, darkish-brown spots and dots, which slightly raise from a striated and dirty-brownish surface, through which the choroidal vessels can be faintly seen. The retinal elements are totally destroyed in this area, the irregular outlines of which are bordered with a darkish rim. There are no other anomalies on the retina.

General health has always been good. There is no history of syphilis or malaria. Liquors are not used at all; tobacco but moderately. Urine is normal, of acid reaction and of specific gravity of 1018.

The only assignable cause of the loss of his eyesight patient can give is the poor, inadequate light, under which he has been obliged to do heavy work through long years. The right eye, which has been blind for two years, has begun suffering under similar symptoms, to those under which its fellow is now laboring.

My treatment consisted in the use of mild derivatives and syrupus Giberti in moderate doses, in connection with periodical applications of fleur-le-loups. The improvement of the morbid process progressed slowly but steadily. The first change for the better was noticed in the condition of the scotoma, which gradually became brighter, smaller and more transparent, and finally contracted to a fine, pellucid spot, which remained in the centre of the visual field long after the color-perception had been restored to its normal condition, and vision had increased to $\frac{12}{15}$. The improvement in the functional disturbances was, however, not

* Egyptian Mythology.

† See "Five Lustra of Ophthalmic Practice." Wiesbaden, Bergman, 1882.

attended with any material change in the morbid process proper of the retina. The latter remained in full height until the fifth week of treatment, when vision had reached $\frac{15}{20}$ and scotoma had considerably diminished. Then only reparation commenced, starting with the absorption of the retinal exudation, which now proceeded very rapidly. The retrogressive course of the yellowish-white points and dots began at the seventh week of treatment, after vision had reached $\frac{15}{15}$ and scotoma had entirely vanished. The points and dots faded but gradually, disappearing from the view only at the end of the twelfth week of treatment. The extravasations of blood remained longest, and winter passed off before absorption had completed its course. A few pigment deposits were the only traces of the affection left on the retina.

Case 2. Butcher G., 39 years old, applied to me February 7, 1880, on account of central obscuration in the visual field of his right eye, which has developed during the last few days. Examination showed:

*Right Eye.*—V=$\frac{20}{20}$. Jaeger 7. Visual field normal in its outlines, but showing central scotoma of elliptiform shape, the axes of which, measured at one foot distance from the perimeter, are respectively 15 and 9 lines in length. Within this scotoma the color-perception is totally lost. White appears gray. Refracting media are transparent. Optic disc, peri-papillary border and vessels are normal. Inside from the optic disc, at a distance from the latter of two papillæ in diameter, there are numerous ecchymoses, clustered close to each other in radiating streaks, which form a crescentic figure, with the opening towards the macula lutea. The retinal tissue between the ecchymoses and macula lutea is slightly infiltrated and swollen, and covered with numerous minute fatty-glistening spots, which are either isolated or in groups. There are no morbid changes in the macula lutea itself, but the latter is dark red, and shows in its lower border a fine hemorrhagic effusion. The whole remaining surface of the retina is covered by a very delicate, diffuse opacity, and sprinkled over with numerous white, opalescent dots, which, however, keep aloof from the course of the retinal blood-vessels. The latter are normal. Only one venous branch, which, emerging from the optic disc, runs downwards, and turns abruptly to the macula lutea, is slightly hyperæmic and tortuous.

*Left eye* is normal.

Patient is a perfectly healthy man, of robust constitution. There is no history of syphilis, or of intemperance either in liquors or tobacco. Urine is normal, of acid reaction, and of specific gravity of 1019. No assignable cause of the affection can be given.

The result of the treatment with subcutaneous injections of muriate of pilocarpine (half a grain pro dosi) was as follows:

*After the Twelfth Injection.*—V=$\frac{20}{30}$. Scotoma separated into two lateral halves, leaving entirely free the fixation-point.

*After the Twentieth Injection.*—V=$\frac{20}{20}$. Instead of the scotoma there are only two delicate lateral shadows, which do not impair vision. They entirely vanish after a short time. The white dots on the retina have faded but very little. The color of the macula lutea is slightly reddish, and the hemorrhagic effusion in course of absorption. The region between the macula lutea and the optic disc has regained its transparency, and the white deposits have disappeared in some parts, while they have only become fainter and sparer in others. The crescentic figure, formed by the striated extravasations of blood near the optic disc, has broken into small reddish spots and points, raising from a reddish-gray base.

With this condition of his eye patient is discharged from treatment April 20th. The favorable result remains stationary. The pathological changes in the background of the eye subside but slowly, leaving finally no other alterations on the retinal tissue but a few pigment-spots.

Case 3. Merchant L., 51 years old, applied to me, December 19, 1882, with the complaint that a cloud has developed during the last few weeks before his left eye, which greatly interferes with the central fixation of objects. The vision of his right eye has also failed, although morbid symptoms proper have not yet come into notice. Examination shows:

External appearance of either eye normal. Vision of the left eye $\frac{12}{30}$, of the right eye $\frac{12}{20}$. The right eye reads with the help of convex 10 Jaeger 1, the left eye only Jaeger 4. The outlines of the visual field in either eye are limited upwards and inwards, to a greater extent in the left eye. The latter, shows besides a central scotoma of oval shape, the axes of which, measured at one foot distance from the perimeter, are 13 respectively 8 lines in length. Within this scotoma the color-perception is lost for red and green, and slightly impaired for blue. The right eye presents a small area around the fixation point, within which the principal colors appear somewhat fainter than in the other parts of the visual field. Refracting media are normal in either eye.

*Left Eye.*—Optic disc and blood-vessels normal. Peri-papillary region distinct. The inner border of the optic disc is surrounded, wall-like, by numerous, striated, linear extravasations of blood, closely aggregated to each other. The whole region between the striated extravasations and the macula lutea is occupied by numerous, minute, whitish-yellow points, which raise, either isolated or in groups, from a gray-reddish and slightly infiltrated surface. Inside from the macula lutea, almost touching its border, there is a corona of punctiform ecchymoses, with a whitish speck in its centre. The fovea centralis itself contains a small pinkish spot. In the vicinity of the morbid deposits the veins mostly are dark-red and tortuous, the arteries thin. Some vessels, which run directly from the optic disc to the affected parts of the retina, are veiled by the retinal infiltration. The remaining surface of the retina with its vessels presents no anomaly whatever.

*Right Eye.*—Optic disc and vessels normal. Peri-papillary region distinct. Two minute, linear extravasations of blood are situated upwards and inwards from the papillary border, and several larger ones near the macula lutea, the color of which is dark-red. On the space between the macula lutea and the optic disc there are scattered about ten to twelve whitish dots; two somewhat larger, yellowish and fatty glistening spots are situaled near the macula lutea. The retinal tissue in this region is slightly infiltrated, and the veins are hyperæmic. The remaining surface of the retina is absolutely normal.

Patient is a healthy man of robust constitution, whose organs are in perfect order. Urine is normal, of acid reaction, and of specific gravity of 1019. He is in all other respects temperate but in the use of tobacco, in which he has immoderately indulged for many years past. He smokes daily from about fifteen to twenty very strong and large cigars. No other cause of the affection could be elicited. Starting from the supposition that the abuse of tobacco might stand in direct connection with the affection, I tried to prevail upon the patient to refrain from his bad habit, but to no purpose. His passion was stronger than his will. The conclusion would certainly be too rash that the abuse of tobacco had had nothing to do with the affection; but on the other hand, we cannot shut our eyes to the fact that treatment had the effect to cure the trouble, notwithstanding the injurious influence continued to act in full force.

The application of fleur-le-loups, to which I first resorted, had the following result:

AFTER THE FIRST APPLICATION.

*December* 26.—Vision of the left eye $\frac{1}{20}$. The cloudiness before the eye much brighter. Central scotoma smaller and more pellucid.

Vision of the right eye $\frac{2}{15}$.

AFTER THE SECOND APPLICATION.

*January* 5, 1883.—Vision of the left eye $\frac{1}{15}$. Cloudiness almost subsided. The central scotoma is replaced by a fine shadow, within which there is a dullness for the finer shades of colors, whereas the principal colors are correctly distinguished. Vision of the right eye $\frac{1}{12}$. Perception of colors and fixation-point normal.

*January* 13.—Vision $\frac{1}{12}$ with either eye. Binocular vision $\frac{1}{10}$. Field of vision normal in either eye. The central shadow in the left eye is brighter and more pellucid.

The morbid alterations in the retina are in the course of resorption in the right eye, but unchanged in the left one.

AFTER THE THIRD APPLICATION.

*January* 18.—Vision of the right eye $\frac{1}{12}$. Ecchymoses fainter, thinner, and partly resorbed; the whitish-yellow dots have considerably faded.

Vision of the left eye $\frac{1}{15}$. Pathological deposits in the retina unchanged. Two fresh, small extravasations of blood near the macula lutea. The central shadow more opaque. The principal colors appear fainter and dimmer. Field of vision normal.

The diaphoretic treatment to which I now resorted, in combination with small doses of bichloride of mercury, had the most favorable result.

March 22, examination showed:

Vision of the right eye $\frac{1}{5}$. The white dots totally resorbed; only a few traces of the extravasations of blood. The affected part of the retina restored to normal condition.

Vision of the left eye $\frac{1}{12}$. Scotoma vanished. Color-perception normal. Pathological changes in the retina in full progress of resorption. The whitish dots less numerous and but thinly scattered in the vicinity of the macula lutea. The latter presents normal appearance. The radiated ecchymoses partly resorbed; the larger extravasations of blood flatter and brighter. The veins less tortuous, the arteries more filled up.

In this condition of his eyes patient reassumes in full the duties of his business, and withdraws from any further control.

2006 *Arch street, Philadelphia.*

—Mr. Lister has been offered and has accepted a baronetcy.

## A NEW BATTERY SOLUTION.

BY CARL SEILER, M. D.,

Lecturer on Diseases of the Throat and Nose and Instructor in Laryngology at the University of Pennsylvania.

Every one who has had much to do with batteries for medical purposes and for the galvano-cautery, in which bichromate of potash solution is used in connection with sulphuric acid as the exciting fluid, has been annoyed by the formation of ruby-colored crystals. These crystals, which are very hard and insoluble in cold water, cover the surface of the zinc plates, and are formed in the interstices of the carbons, besides forming a thick and hard crust at the bottom and at the sides of the cup containing the fluid. They are more readily formed in cold weather than during the warm season, and can be dissolved only by boiling water. Being non-conductors of electricity, they increase the resistance of the carbons to such an extent as to materially interfere with the proper action of the battery, and thus often only a feeble current is obtained from a powerful instrument. These crystals, commonly called chromo-alum, are, in reality, a double salt of chromio-sulphate of potash, the combination being favored by the electric current and by exposure of the elements of the battery to the air.

The reader, not well versed in the chemistry of batteries, may ask, Why not leave out the bichromate of potash, and only use a solution of sulphuric acid and water? The answer to this question will explain the chemistry of the new solution. When two elements, say a carbon and zinc plate, are placed in a jar containing acidulated water, and are above the solution connected by a wire, an electric current is established, which decomposes some of the water into its constituents, hydrogen and oxygen. The former, together with the acid, enters into combination with the zinc, while the oxygen, in the form of small bubbles, adheres to the surface of the carbon, and being a non-conductor of electricity, soon stops the action. This is termed polarization. In order to prevent this, or at least reduce it to a minimum, a substance is added to the solution, which has a strong affinity for the oxygen, and thus prevents the coating of the carbon plate. There is, perhaps, no better deoxidizer known than chromic acid, and as it forms a large part of the cheap commercial salt bichromate of potash, this is added to the sulphuric acid and water to form the battery solution. It is, therefore, the chromic acid which acts, being set free from its combination with the potash by the action of the sulphuric acid, and we thus have a solution of sulphate of potash and of chromic acid, with a surplus of sulphuric acid and water, in our existing fluid. If pure chromic acid instead of bichromate of potash is used in making the fluid, no crystals can be formed, since no potash is present; but the crystallized chromic acid is a very expensive article, costing nearly $2 per pound at wholesale rates. A crude non-crystallized chromic acid can however readily be made, and when added to the sulphuric acid and water will give excellent results, the plates remaining free from all crystals, and the fluid retaining its full force to the very last. A fluid made according to the following formula has given me great satisfaction in my galvano-cautery battery, and it can be used, diluted one-half with water, for the ordinary medical batteries:

| | |
|---|---|
| Bichromate of potash, | 2 pounds. |
| Hot water, | ½ gallon. |
| Sulphuric acid, | ½ gallon. |

Dissolve the bichromate of potash in hot water, and when cool add to it the sulphuric acid. This should be mixed in an earthen vessel, as the sudden evolution of heat is very apt to break a glass bottle. When cold, place the mixture, which will be quite thick, in a glass funnel, the tube of which is partly closed with asbestos, and drain off all mother liquor, which is a saturated solution of sulphate of potash. Then re-dissolve the parts remaining in the funnel in 1½ gallons of water, and add to it 2 quarts of sulphuric acid if the fluid is to be used for the galvano-cautery battery; but if it is for the ordinary medical battery, 1 quart of sulphuric acid is sufficient.

1346 *Spruce street.*

# HOSPITAL REPORTS.

## A CLINICAL LECTURE DELIVERED AT THE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

BY WILLIAM PEPPER, M. D., LL. D.,

Provost and Professor of Clinical Medicine in the University of Pennsylvania.

Reported by WILLIAM H. MORRISON, M. D.

### Infantile Paralysis.

GENTLEMEN: The first patient which I shall show you to-day is this child. The mother gives us the following history: She has had two children, one of whom died of cholera infantum. This little girl is nine months old. About the middle of July (five months ago), it was seized with general paralysis, and could move neither its hands nor feet. This was preceded for a few days by feverishness and restlessness. This condition of general paralysis lasted for two days. She then began to regain power in the right arm and left leg. Motion returned to the arm sev-

eral days before it did to the leg. In the course of three or four weeks, she began to use the left hand. Further than this, there has been no improvement in the ability to move the limbs. She has had no spasm of any kind, nor has she had any injury sufficient to suggest a traumatic origin of this paralysis. She had not been exposed to wet or dampness at any time.

This is an example of infantile paralysis, but it differs from ordinary cases of this disease, in the fact that the paralysis has been so general. As you are aware, infantile paralysis commonly comes on about this period of life, that is, during the first dentition, somewhere between the ages of twelve and thirty-six months. The causes of this affection are obscure. It sometimes undoubtedly comes from direct exposure and severe chilling of the body, but in many cases, it comes on without any apparent adequate cause. It is usually preceded by just such symptoms as those described by the mother of this child. For a few days, the child will evidently be unwell, feverish, restless, indisposed to be moved, crying and fretting, with a poor appetite, and perhaps with some little gastric disturbance, as is shown by vomiting. The child is, perhaps, put to bed in this condition without any evidence of paralysis, but in the morning it will be found to be paralyzed. The disease comes on then after an uncertain period of indefinite sickness, which is evidently sympathetic with the trouble in the spinal cord.

This case illustrates very distinctly another common feature of infantile paralysis, namely, that nearly always the loss of power is greatest at the beginning of the attack. The paralysis affects a larger number of members or muscles than remain permanently paralyzed, so that after a few days the paralysis begins to clear up and those parts which have been least affected regain their power, leaving a certain number to be permanently paralyzed, or paralyzed for a longer period.

In this child, neither the bladder nor the rectum have been involved. This is the usual history. The deeper portions of the cord where the fibres going to the bladder and the rectum traverse, are not, as a rule, involved in the disease; for, as you know, the seat of the lesion in infantile paralysis is in the anterior horn of gray matter of the cord, and in the anterior column in this vicinity. The condition in the beginning is one of congestion, irritation, and swelling. We can, therefore, readily understand that in these parts where the lesion is less severe, it may pass away leaving no organic change, and thus we may have cases of infantile paralysis which recover completely in the course of two or three weeks, more commonly owing to the extreme sensitiveness of the spinal system. At this early age we find that some part of the spinal cord is so badly hurt that it undergoes degeneration and atrophies, or at least tends to do so. In such cases, the paralysis becomes permanent, and is followed by wasting of the affected muscles. Thus it is that this disease is often called atrophic infantile paralysis, because it is so frequently followed by wasting of the muscles which remain palsied; but this again depends upon the extent to which the antero-lateral column and anterior horn of the cord have been injured by the original cause. This may leave a more chronic trouble, which will pass away, leaving the integrity of the cord unimpaired; or it may be followed by wasting of the large multi-polar cells, which have a trophic influence upon the muscles, and this wasting is followed by atrophy of the corresponding group of muscles.

Let us now examine the condition of the affected muscles in this case. The child can move the right arm and hand very well. When an object is presented to her left hand, she tries to raise the arm to grasp it, but she is unable to do so, as the muscles of the shoulder and arm are paralyzed. When I put the object in her hand she clutches it firmly, showing that the flexor and extensor muscles of the hand have regained their power. This case well illustrates the way in which the disease dissects out particular muscles or groups of muscles, apparently without reference to their position. Here we find the shoulder and humeral muscles of the left side involved, and naturally, we should expect to find the muscles of the hand affected in the same way; but it is not so. There is considerable power in the right leg, and during the past few days the child has regained some power over the left limb. There has as yet hardly been time for much wasting of the muscles to take place, but I find that the muscles around the shoulder are decidedly wasted. As long as the muscles have not atrophied, you should never despair of a perfect cure. The case may keep on improving even after it has lasted for a long time. When the muscles have wasted there is great reason to fear that they cannot be restored to their natural condition.

In treating the early stage of this disease, I think that it is well to act upon the supposition that there is irritation and congestion of the spinal cord. Counter-irritation along the spine and the use of ergot, belladonna and iodide of potassium internally, are indicated. At a later stage of the disease, when as much of the paralysis as will clear away has passed off, and there remains only the permanent paralysis which is associated with a serious lesion of the spinal cord, this line of treatment does not produce good results. We then have to depend upon remedies to promote the general nutrition, as iron and cod-liver oil, with correct hygiene, taking great care that the child is dressed properly and not exposed to dampness, draughts, etc. Friction of the skin should be employed to maintain the circulation, for the child cannot take that incessant exercise by which young children maintain a healthy condition of their muscles and functions. In addition to this, there should be treatment especially directed to the paralyzed parts, hoping that the tone of the spinal centres will be sufficient to enable them to maintain their integrity and prevent disintegration and atrophy of the nerve cells, which will be followed by wasting of the corresponding muscles. I do not know that we have any remedy that specially influences the nutrition of these important nerve cells. Strychnia has no effect upon them, but acts only upon the motor nerves and the muscles. It is proper to use strychnia at a late period of the case, and it may be administered by the mouth or hypodermically, being injected into the affected muscles. The object of this treatment is to improve the nu-

trition of the muscle, and not to act upon the spinal cord. Massage, friction and passive movements should also be employed with the same object. The circulation of the skin should be stimulated by friction and warm clothing. Good results are often obtained by putting the affected member under an air pump and exhausing the air. The limb is as it were enclosed in a large cupping glass, a vacuum is created, and the blood is drawn into the part. This carefully repeated is frequently of service.

In private practice, we have scarcely the means of treating these patients as they should be treated. All that form of apparatus which has been brought to such perfection in Sweden serves an excellent purpose in the treatment of atrophic infantile paralysis.

Electricity is an important agent in the treatment of this affection, but its use requires judgment and skill. That current is employed which will give contractions of the paralyzed muscles, and the interrupted galvanic current is practically the only one which is of service. It is to be used of such a strength and with the current interrupted at such a rate, and applied over the nerve points, the nerves themselves, or the muscles, according as you get the best results. There is no fixed rule to be laid down for the use of electricity, save that the current should be moderate and used in such a way as to secure contractions of the affected muscles. As many of you know, there is a special form of reaction of the muscles to electricity, which, however, I shall not consider to-day, which indicates the approach of disintegration of the cord. It is a reversal of the normal relation of the muscles to the interrupted galvanic current, and the detection of this is, although not absolutely of unfavorable prognosis, a serious sign.

What we do for these cases in private practice is to promote nutrition by the use of iron, cod liver oil, later employ strychnia, keeping up friction of the skin, and training the parents in the use of massage and passive movements, carefully regulating all matters of hygiene, and if we have time and a suitable battery, apply the galvanic current in the way which I have suggested. These are cases which are more satisfactorily treated in institutions especially designed for this purpose, but the great objection to this treatment is its costliness, and we should have, in connection with our general hospitals, suitable apparatus for the treatment of these cases.

These cases require a long treatment, and if this is neglected the paralyzed muscles may pass into a condition of hopeless atrophy from disuse, and although the trophic centres of the cord may not be ruined by the original disease, the muscles from lack of proper treatment become hopelessly wasted.

Attention has been called to the projection of this child's stomach. Occasionally the dorsal muscles, or abdominal muscles, are paralyzed, allowing the body to fall in all directions, or great protuberance of the stomach when the child sits up. This is one of the rare cases in which there is paralytic distension of the abdomen. I have seen this condition on a number of occasions, although it has been recently described by a specialist as though it were something quite new.

**Dupuytren's Contraction of the Tendons of the Hand, with Trembling.**

Our next patient is a painter. He was born in Scotland, and came to this country two years ago. He comes with the statement that he has trembling of the right hand and contraction of the flexor tendons. Both his parents are living, and, as far as he knows, there is no gout or rheumatism in the family. He had two attacks of rheumatism before he came to this country, but the heart did not suffer in either attack. I refer to this point, because this contraction of the flexor tendons, which was described by Dupuytren, and is often called Dupuytren's contraction of the tendons, is one that I have commonly seen in persons of a gouty or rheumatic diathesis. It is often associated with sub-acute rheumatism. It comes on at different periods of life, but usually much later than that at which our patient presents it.

He has contraction of the tendons of the little and ring fingers of the right hand. The tendon is thickened, hardened, rigid, and evidently contracted; the fingers are more or less drawn, there is difficulty in fully expanding them, and when force is employed it excites pain. Occasionally this contraction will go on until all the tendons are involved and the hand is reduced to a state of characteristic deformity. It often happens that the affection is symmetrical. In its earliest stage, I have known it to yield to internal alterative treatment. Later, it becomes the subject for surgical treatment, but even after subcutaneous section of the tendon, it will, as a rule, be found that as long as the constitutional tendency continues, the disease will recur and the contraction again present itself.

The affection of the tendons in this patient is associated with trembling of the hand, and as he holds out his hand you see that it is the seat of a general trembling; it is not a fibrillar twitching, the whole member shaking, instead of there being a quivering of individual groups of fibres under the skin. You have probably had your attention called to those curious fibrillar twitchings which appear beneath the skin when the muscles are going to pass into a state of progressive atrophy. In that curious disease, progressive muscular atrophy, one of the earliest symptoms, occurring perhaps before the wasting of the muscle has progressed sufficiently to be recognized, is the appearance of this fibrillar quivering. This is quite distinct from the trembling which this patient presents. The left hand does not quiver as much as the right, and the tendons are not affected to the same extent.

He first noticed the trouble in the right hand about eighteen months ago. He has been engaged at painting for sixteen years. He has never had lead colic or other symptoms of lead poisoning. There is no blue line along the gums. During the past two years he has worked at painting cars, and in a great deal of his work, he cannot use a rest for the hand. Sometimes, when polishing the varnish, his hands are in cold water for one or two days at a time. During the past six months he has begun to use his left hand to some extent in striping, but he is sure that the trembling of the left hand came on before he began to employ it in this way.

The fact that this patient has been handling

lead in various ways for so long a time and has never had paralysis, neuralgia, colic, blue line on the gums, or other evidences of saturnine poisoning, led me to believe that this trembling is not dependent upon the action of lead, but is due to an affection of the sheath of the nerves, similar in character to that which has attacked the tendons. I may be wrong in this opinion, for as you know, the symptoms of lead poisoning are curiously diverse. This may be the result of the action of lead, but I am inclined to connect it with rheumatic tendency and the affection of the tendons.

It will be proper under the circumstances, to put this man on a treatment suitable for lead poisoning. If he can do it, he should give up painting; but as he probably cannot do that, he should keep his hands entirely away from lead, and when painting should, as much as he can, use a rest for the hand. He has been taking a tonic consisting of iron, quinine and strychnia; and also five grains of iodide of potassium three times a day. I would stop the tonic and increase the dose of iodide to ten grains in water on an empty stomach. With this I shall order ten drops of the juice of conium and increase the dose cautiously until we see whether or not it has a favorable effect on the muscular trembling.

**Gastric Disturbance Probably Due to Incipient Cirrhosis of the Liver.**

In this patient we are anxious to arrive at a correct diagnosis, and yet it is a difficult thing to do. He is a laboring man, 52 years of age. His statement is that he has always enjoyed good health, but has used liquor to excess. He states that the symptoms of the present sickness came on only six weeks ago, and expects us to believe that this appearance of extreme illness has been developed within that time. I find it difficult to do this. I think that it is more likely that he has failed to notice the disturbances which may have preceded the condition in which the symptoms have been more acute. For the past six weeks he has had frequent vomiting, has rapidly lost flesh and strength, and assumed this anæmic and cachectic appearance, and yet there has been no fever and no complaint of pain. He has not worked for twelve months, but had no trouble with digestion, and never had vomiting before six weeks ago. He vomits about once or twice a week, and usually in the morning. The matters vomited consist of "sour stuff," and sometimes in part of the food taken the previous evening, but there has never been any blood vomited. The bowels are opened without medicine about once in every three days. His best weight was 160 pounds. He thinks that he now weighs about 125 pounds. During the past six weeks he has lived chiefly on liquid food, taking about a quart of milk a day. If he takes solid food, it excites vomiting.

The rapid development of this vomiting makes it hopeful that it is not due to malignant disease. It may prove to be a case of ulcer of the stomach, but the absence of pain and tenderness, the period of the vomiting, occurring only in the morning, the character of the matters vomited, and the absence of blood, are all against the idea of ulcer. This leads us to hope that it may be one of those cases of gastric catarrh with congestion of the liver, which may occur in a person broken down by imprudence in the use of liquor. Some of these cases very closely simulate carcinoma of the stomach, and will often give you considerable embarrassment. The fact that this is so should warn you against pronouncing an unfavorable diagnosis and prognosis. If you are unable to detect actual thickening or a distinct tumor, be careful how you are led by the severity of the symptoms, the failure of flesh and strength, and the appearance of emaciation, into the assertion that the patient has carcinoma. Of course, you are forced to consider this possibility; you may even be forced to suspect cancer; but beware how you communicate that suspicion to any other person, and you should carry out that treatment which would be of service if the disease were not malignant. If the disease is malignant, this is the line of treatment which will do the most good; whereas, if you allow yourself to hold the opinion that there is incurable organic disease of the stomach, you will lose heart, and if you tell the patient, he will of course feel that there is no use in pursuing any special line of treatment, at least with you, if you know beforehand that you are going to do him no good.

Let us now examine the stomach. The abdominal muscles are rigid, but by a little gentleness and perseverance, I am able to get my fingers down on the aorta, and if there was any distinct thickening of the walls of the stomach, I should certainly be able to detect it. The results as regards the stomach are therefore negative.

The dullness of the liver begins at the sixth rib, and does not extend below the border of the ribs. The liver is small. You have heard a great deal about the gastric symptoms of developing cirrhosis, and this is a condition which must constantly be borne in mind in diagnosing between gastric carcinoma and other causes of vomiting and wasting.

In view of the distinct history of alcoholism, the diminished area of hepatic dullness, and the absence of any demonstrable thickening or lump, I am disposed to explain this case as one of chronic gastric congestion and catarrh, connected with portal obstruction from incipent cirrhosis, rather than a case of carcinomatous disease of the walls of the stomach. Sometimes you will find grave symptoms developed, even when the condition of the liver is still entirely curable, and has not passed into an actual cirrhotic change.

I shall recommend this patient to continue the simple diet of milk and light cereals which he has employed during the past six weeks. All forms of alcohol are to be avoided. Internally I should recommend the use of bi-chloride of mercury with no other remedy, given moderately diluted on an empty stomach. I should begin with $\frac{1}{120}$ of a grain in two ounces of liquid, and gradually increase to $\frac{1}{24}$ of a grain three times a day, as it is tolerated and produces good results. In a month we shall be able to decide as to the effect of this treatment.

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—Dr. Brand, of Stettin, was the first man to introduce (in 1861) the treatment of typhoid cases by cold baths.

## NEW YORK HOSPITAL.

CLINIC OF PROF. WILLIAM H. DRAPER.

Reported by W. H. SEELYE, A. M., M. D.

### Traumatic Peritonitis.

The patient is thirty-five years of age, a native of Ireland, married, and is employed as a stoker at the Metropolitan Gas Works, in this city. He was admitted to the hospital December 13. He gives a purely traumatic history. He was perfectly well until the night of December 12. He was then at work in the gas factory, and was struck violently in the abdomen with a heavy iron coal-shovel. Though suffering intense pain, he was taken home, and then he suffered from shock, and had a fever, followed by a profuse cold sweat during the night. He had no chill. There was great pain and tenderness in the abdomen, which continued until he was brought here, at 7 a. m., in a greatly prostrated condition. He has passed water this morning, but was not able to before, He has had no movement from the bowels since the injury was received. Has not been able to sleep because of pain and restlessness. The pain is increased on motion and by pressure. He finds greatest relief in the dorsal decubitus, and with his legs drawn up and knees flexed. On admission, his pulse was 111, respiration 28, and temperature 101.8°. His urine was drawn off with a catheter, and it had a specific gravity of 1.028, contained no albumen or casts, had an acid reaction, and was of a light red color.

I do not doubt, gentlemen, that most of you have already determined from the history, that the patient has peritonitis, and a peritonitis due to a traumatic cause. And now the question arises whether this peritonitis is simply the result of a contusion of the walls of the peritoneal cavity, or whether some more serious injury has been done to the contents of the abdomen. Upon questioning the patient, and upon examination by palpation, it is found that the point of greatest pain and tenderness is to the right of the median line, and below the level of the umbilicus, that is, in the right iliac region, and it is found also that the force of the blow was received upon one side of the abdomen, and not directly in the median line.

Upon placing my hand over the abdomen, I not only find tenderness everywhere, but I get increased tenderness, and a sense of resistance to pressure and a dullness on percussion over the limited region I have described. It would seem, therefore, that the injury done, whatever it is, must have been inflicted upon some of the structures included between the median line and the ilium, and below the line of the umbilicus on the right side. In this region it is possible to conceive of an injury being inflicted upon a distended bladder, or upon the cæcum, or some portion of the intestines.

You remember that in the history it was said that although he was suffering intensely from pain caused by the blow, yet he was allowed to go home, and the evidences of a specially severe injury did not occur until after he got home, and these were the ordinary evidences of shock and prostration. He was brought here at the end of twelve hours after the injury, and was immediately put upon the opium treatment, and enough of the drug was given to him to relieve the pain. The progress of the case since has not been satisfactory, and this seems to make it more certain that the injury was of a more serious nature than a simple peritonitis from contusion, and that the force of the blow acted directly upon some of the abdominal viscera. Now I do not believe it was the bladder that was injured, because he had emptied it only three hours before the accident, so it could not then have been very full and distended. And besides, he has passed water since, which he could not have done if the bladder had been ruptured. He has not had any action from the bowels since he came in, and it has not been thought desirable to attempt to procure one, for there is no question as to the existence of intestinal obstruction here. I think it is possible that there has been a rupture either of the cæcum, the ascending colon, or some part of the small intestine, with an escape of its contents into the cavity of the peritoneum; and that explains the serious character of the peritonitis. From the rapid failure of the patient, and from the general character of the symptoms, I am therefore led to believe that we have here to deal with a peritonitis which is secondary to an injury of some abdominal organ. For if it were due to a simple contusion of the peritoneum, the prognosis would not be so serious.

I said that this man was put upon opium as soon as he came in. And this, as you know, has now become the classical treatment of peritonitis. It is a well recognized rule now, that the diagnosis of peritonitis being once established, you are to direct all your efforts to the controlling of the inflammation, and you are to wait until it has subsided before you attempt to treat the cause. This rule would not apply invariably to all such cases as come within the province of the surgeon, but it would apply to those cases where there is fæcal obstruction, and a peritonitis depending upon a rupture of the intestines from typhlitis, typhoid fever, or other causes. The opium plan of treatment is now, I think, much more moderate in its application than it was when I was a student. Twenty-five years ago, when the plan of treating puerperal peritonitis by opium was first brought to the notice of the profession by Dr. Alonzo Clark, there was much interest excited; and there was a good opportunity for testing its efficacy, for there was about that time an epidemic of puerperal peritonitis, and there were many cases in the city. At that time opium was given in such large quantities that to watch its effects, the presence of a medical man of intelligence was rendered necessary, and so the physicians used to get medical students to come and sit by the bedside of the patient night and day, in order to watch the frequency of the respirations, which was the test by which the size of the dose was regulated. Dr. Clark was not satisfied with merely relieving pain and tenderness, but he thought it necessary to produce semi-narcotism. And it was found that there was an astonishing tolerance of this drug in patients suffering from this disease. For you could sometimes give them from a quarter of a grain to a grain of morphia every hour or two, and still keep them entirely conscious, but in a somnolent state, from which they could easily be

aroused. It was then thought safe to reduce the respirations to five or eight a minute if necessary. But I can tell you that, when you get a patient breathing only five times a minute, you had better proceed with some discretion. Yet I have seen the respirations reduced to seven in two minutes. But I can assure you that this is not a very pleasant condition of things to contemplate, especially if you have yourself administered the drug. Still, even with this amount of opium, the patient can be aroused and will answer questions intelligently. But accidents have occurred by carrying the narcotism so far, and I believe that most practitioners are now satisfied with a reduction of the respirations to twelve or fifteen a minute, and with simply making the patient comfortable; and for this purpose a much less quantity of opium is necessary. In most cases you need not give more than one grain every hour or two, and a safe plan is to begin with one grain every hour, and to repeat this dose until you get relief from pain, and after that to give it according to the necessity of the case. This patient has had fifty-eight minims of Magendie's solution since six o'clock this morning, that is, within nine hours and a half, which is equal to six minims, or one grain of opium per hour. His eyes are beginning to show the effect of the opium, for the pupils are considerably contracted, though not to pin-points by any means. He is also perspiring freely. One ounce of whisky per hour is being administered because of the rise of temperature. When you find this association of symptoms accompanied by a sudden rise of temperature you may be pretty certain of the result; for in peritonitis, as well as in cerebral diseases and apoplexy, a rise of temperature signifies that the end is approaching. Since this morning this man's temperature has run up from 101.4° to 104.2°, and his pulse is now 150 and respiration 15. Observe the characteristic position which the patient occupies, lying on his back, with his legs and thighs drawn up.

## NOTES FROM THE PHILADELPHIA HOSPITAL.

### Infantile Eczema.

Dr. W. H. Parish showed two cases. Both the children were apparently healthy, but were bottle fed, which was probably the cause of the eczema. This is an exceedingly troublesome disease to cure, and will oftentimes persist until you wish your patients were in Europe or in Florida. The scabs must be removed as fast as they form, and this can best be done by the aid of a starch poultice; when you remove it the scabs will come with it. To the raw surface apply benzoated oxide of zinc ointment; if there is much cutaneous irritation, dilute the ointment with ¼ vaseline. For chronic cases he uses an iodide of lead ointment, 10 grains to one ounce of cocoa butter. Internally, he will give Fowler's solution, one-half a drop thrice daily to a child aged seven months.

### Deep Mammary Abscess.

Here was œdema and swelling in the breast of a puerperal woman, who has had a chill. No fluctuation can be detected, but Dr. Parish will make an incision; for it will do no harm, even if there is no pus, and if there is, it will give it a vent and prevent it from burrowing. He did strike pus, but had to go deep for it. There had been an escape of a few drops of pus from the nipple, which caused him to suspect its presence, in spite of the absence of fluctuation. The breast will be poulticed, and after the tenderness disappears he will strap it.

# MEDICAL SOCIETIES.

## OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated meeting, December 6, 1883. The President, R. A. Cleeman, M. D., in the chair.

Dr. W. Goodell exhibited two cysts of the parovarium, and remarked: Both patients got well; he indeed had never lost a patient from whom he had removed a parovarian cyst. In both cases a correct diagnosis was made previous to the operation. One interesting diagnostic point was the complete absence of the *facies ovariana*. The color in the cheeks was good, and the countenance was free from the anxious expression present in cases of ovarian tumor. One tumor had existed for ten years, the other for one. Another important point in the differential diagnosis is not only the flaccidity of the tumor, but its variable degrees of flaccidity. Upon inspection, it is seen to reach to the sternum, and seems to occupy a large portion of the abdominal cavity, but where the hands are placed upon its sternal edge, it can be compressed to the level of the umbilicus. An ovarian cyst on the contrary is hard and uncompressible. Exceptions to this rule are very rare, that is, either a tense parovarian cyst, or a flaccid ovarian one. A third important distinguishing point is the long time—ten years in one case—which the tumor existed, and further, without marked deterioration of health. After being tapped these tumors usually refill, but occasionally they do not, and a cure is thus brought about. The fluid withdrawn has been in every case limpid and generally colorless, but it has sometimes had in his experience an emerald tint. These tumors are generally free from serious adhesions, but if in an operation for the removal of one, adhesions should exist where for any reason their forcible separation would be unadvisable, or the cyst were intra-ligamentous, he would not hesitate to leave the adherent portion of the cyst-wall, or the whole cyst itself, after making a big hole in it, as the fluid it secretes is bland and unirritating to the peritoneum.

Any one examining one of these cysts for the first time would consider it to be of ovarian origin; for it is only by patient search that the ovary can be found spread out over the cyst-wall. The microscope will decide with certainty in any otherwise doubtful case. The tumor is covered with a beautiful net-work of veins.

When a cyst of the parovarium exists on one side, the ovary of the opposite side is usually found to be diseased and should be removed. In these cases the remaining ovary was seen to be enlarged and the site of a small ruptured cyst was pointed out. The fallopian tube was also enlarged, and the terminal vesicle of the fallopian tube, or the hydatid of Morgagni was enlarged and cystic.

This hydatid sometimes attains the size of an orange, and often ruptures spontaneously without any bad effects. A few years ago one of these small cysts ruptured while he was making an examination of the patient to ascertain its character.

Dr. Goodell exhibited a

**Cancerous Womb Removed per Vaginam.**

In view of the very fatal statistics of the operation for the removal of the womb or the radical cure of uterine cancer, he had been unwilling to perform it. In most of the cases where the disease had been seen early enough by him to give a chance of success, the patient had been unwilling to take the risk. On one occasion, when every preparation had been made to operate, the patient had a convulsion, and an examination of the urine showed a high proportion of albumen, in consequence of which he refused to operate. About a month ago, Dr. Chas. W. Dulles called him in consultation to see a patient in whom the carcinomatous condition was limited to the anterior lip. The womb was movable. The case was put frankly before the patient, and all its dangers pointed out. The choice of them being given to her, she decided, after due consideration, to take the risks of the radical operation. The operation was not as difficult as he anticipated.

The first step in the operation was to scrape away all cancerous tissue and to sear the remaining surface with Paquelin's cautery. The vagina was then thoroughly cleansed. A stout thread was passed through the cervix, to draw down the womb, instead of using a volsellum, the handles of which would be in the way. A circular incision was made around the cervix, and the tissues were stripped up anteriorly and posteriorly to the reflection of the peritoneum, and laterally to the insertion of the broad ligaments. Finally, the peritoneum was opened, and the womb retroverted into the vagina by means of the obstetric crochet passed over the fundus. A strong thread was now passed through the body of the uterus, by means of which to manipulate it more easily. A ligature was now passed around the broad ligament of the right side and secured it *en masse*, and a second double ligature was passed through it and tied on opposite sides. This side of the broad ligament was then divided, the uterus drawn down and the ligament of the left side secured in a similar manner and divided. The vaginal wound was closed and dressed with iodoform and cotton. A frank peritonitis set in on the third day, and proved fatal on the fourth. The result made him doubtful whether the operation is ever justifiable; he, indeed, felt disposed to avoid it whenever possible.

Dr. E. E. Montgomery inquired about the feasibility of using the galvanic wire ecraseur to divide the broad ligament, keeping the wire at a low red heat and dividing the tissues slowly, and avoiding the necessity for a drainage tube. Another method which he had been revolving in his mind was by means of the galvanic knife to dissect out the uterus, leaving the peritoneum intact, thus imitating to a certain extent the operation of Dr. Marion Sims of scraping and the use of zinc chloride.

Dr. Goodell thought that Dr. Montgomery's galvanic wire would get too hot as the loop became small, and would then divide rapidly, like a knife, and incur the danger of secondary hemorrhage. He fears that the steam generated by the hot wire would penetrate the peritoneal cavity and have an irritating effect. He has a galvanic cautery battery, but has not used it since the introduction of Paquelin's benzoline cautery, as he finds the latter far more handy and manageable. He thinks Dr. M.'s suggestion of shelling out the uterus a very good one.

Dr. Montgomery exhibited through the courtesy of Dr. W. H. Warder the

**Uterine Appendages**

which had been removed from a young lady for the relief of dysmenorrhœa which had resulted in physical and mental failure. Menstruation commenced at the age of fourteen years, had always been painful, and had developed hysterical manifestations. Bathing at the sea-shore had at one time stopped the periods for three months. After this her health failed. Her mind had been seriously affected for the last three years, and she would run away or do herself some violence at the menstrual periods if not closely watched. Examination: The uterus enlarged and tender; there was profuse leucorrhœa. The os uteri was dilated, and the uterine cavity scraped and cauterized with carbolic acid and bromides, etc., used internally, but no improvement resulted. The ovaries were removed to-day through abdominal section; cat-gut ligatures were used. The ovaries are very much enlarged, and contain small cysts. The abdominal wound was closed with silk sutures, and covered with an impervious dressing of collodion, cotton, etc.

**Hystero-Epilepsy as a Complication of Pregnancy.**

Dr. William H. Shipps, of Bordentown, N. J., sent the following contribution:

Briefly defined, hystero-epilepsy is a term applied to an abnormal neurotic condition in which are manifested certain phenomena, characteristic both of hysteria and epilepsy. Out of 276 patients confined at La Salpetriere Hospital, Paris, under treatment for various nervous affections, 32 were diagnosticated by Beau, a careful observer, as suffering from this disease. Among this number, the malady assumed either a distinct or combined form, hence he very wisely groups the cases in two classes. In the first, the hysterical seizures and epileptic fits remain distinct, one from the other; to this form he adapts the term given by Landouzy, and designates it as hystero-epilepsy with distinct crises.

In the second class, and the one of which this article furnishes an illustration, the hysterical and epileptic seizures are co-eval, both developing at the same time; to this form the name of hystero-epilepsy with combined crises has been given. The object of this paper is, not to enter into a consideration of the disease as it is met with in general practice, but simply to examine it as a complication of pregnancy, a standpoint from which, fortunately, we are rarely called to view it.

During the early part of March, 1883, I was called to attend a woman said to be in a fit. Arriving at the house, I found, lying on a bed, a young woman, apparently seventeen or eighteen years of age, of fairly vigorous physique, who was striving against the united efforts of two or three neighbors, who sought to prevent her doing

herself bodily harm in the violence of her struggles. Examination showed entire loss of consciousness, eyes open and staring, pupils widely dilated, frothing at the mouth, which was then tightly closed, pulse full and bounding. Inquiry elicited that during the day she had been visiting a friend, herself the subject of some spasmodic affection, and whilst in her company became greatly exercised on some trivial occurrence, and in this state of excitement returned home, which place she no sooner reached than she was seized with a convulsion. Her husband informed me that she was in the third month of pregnancy, and that prior to this morning she had on one or two occasions attacks somewhat similar though of less severity. I at once injected, hypodermatically, one-third grain of morphine, which in a short time was followed by a total disappearance of all spasmodic action, a state of stupor supervening, from which, in the course of three or four hours, she aroused, apparently as well as ever. On the day following I was called to see her, and found her in a state of high nervous excitement, sobbing and deploring the presence of some impending danger, which she, in her imagination, insisted was threatening her. In a short time, the stage of muscular contraction, loss of consciousness, stupor, etc., took the place of hysterical symptoms, finally terminating as before in a return to her normal condition.

Without attempting to follow the case step by step, taking in all its details and noting the many and peculiar phases through which it passed, it is interesting to note that prior to September 23, '83, covering a period of two hundred days, not a day passed without the occurrence of one or more paroxysms. At times the hysterical phenomena would be most marked and usher in the attack; then again, the epileptic fit would take the precedence; always, however, accompanied by the undeniable imprint of the dual disease, hystero-epilepsy. In the inter-paroxysmal period she enjoyed for the most part average good health.

On the morning of September 23d, I was asked to see her in an attack of more than usual gravity. When I reached the house she was profoundly unconscious, and had been so for several hours. The time for her approaching labor being near, I made a vaginal examination, but found no evidence of commencing uterine action. I ordered a hot mustard bath, mustard to the extremities, and bromides the moment she should be able to swallow. In the evening when I again called, her condition was apparently unchanged. I then ordered a blister to the nape of the neck, and left the patient, to return early in the morning. At 7 a. m. a messenger called stating that the woman was now perfectly rational, and to all appearances in labor. I at once responded, and found that she was having bearing-down pains of moderate intensity at intervals of five or ten minutes, mouth of womb dilating, vertex presenting. I remained by the woman's side until 3.45 p. m., when the child, a healthy female weighing 9 or 10 pounds, was born. The labor did not differ from ordinary labors, except that it was only by the utmost vigilance that the woman was prevented from falling into one of her accustomed attacks. After the birth of the child, I gave it to the mother, at the same remarking to her, that as she valued the life of the child, under no circumstances to allow herself to have another convulsion. She promised faithful obedience, and up to the present has not shown the first indication of her old trouble. It should be mentioned that during the entire period the patient was under observation she had daily taken large doses of the bromides and other nervines without any effect, save perhaps in ameliorating the number and violence of the paroxysms. The case is interesting on account of the rarity of the disease as a complication of pregnancy; its persistence throughout the entire period; its resistance to all remedial measures, and the final disappearance of all symptoms after the termination of labor.

Two queries very naturally present themselves: What was the exciting cause of the attacks? Would the induction of premature labor in this and similar cases be justifiable?

In answer to the first query, I attribute the attacks to an action upon the brain and spinal cord, reflex in its nature, and developed or excited by the fœtus in utero.

The happy termination of the case would seemingly offer a negative to the second query; but better judgment will, I think, suggest the wisdom of the operation and the danger of refusing to employ what, theoretically at least, offers the only chance of relief; at all events, in a similar case I would most certainly have recourse to the operation, and expect from it the best results.

# EDITORIAL DEPARTMENT.

## PERISCOPE.

### A New Anæsthetic Mixture.

Dr. William A. Byrd, of Quincy, Ill., has been using a mixture, composed, by measure, of bromide of ethyl, one part; chloroform, three parts; alcohol, four parts. These substances, mixed, form a clear solution, of a pleasant odor, and of a warm, sweetish taste. Dr. Charles Wesley Rook thus writes of its physiological action in the *Jour. Am. Med. Association*, December 15, 1883: I have administered this anæsthetic to a number of patients, varying in age from early childhood to adult life; to those enfeebled by disease or suffering, and to those apparently healthy; for operations comparatively trivial, and for others which were protracted and serious; inducing and sustaining complete anæsthesia, in some cases only for a few moments, while in others for more than

an hour; and in all these cases, with their varying circumstances and conditions, I have observed a remarkable similarity in the physiological actions of this anæsthetic. The stage of excitement or intoxication is brief, sometimes absent; if occurring, is never violent. The stage of spasmodic rigidity of the voluntary muscles seldom occurs; when occurring, it is not extreme. Following these stages, when they are present, or within a few minutes from the commencement of the inhalation, the stage of complete anæthesia is induced, when any unfavorable or alarming conditions or symptoms occurring in the preceding stages, as excitement or rigidity, will be relieved, so that the vital functions are carried on as regularly, and apparently as effectually, as if the patient was in a natural physiological sleep.

The time required to produce complete anæsthesia is from one to three minutes in children, and from three to five, and possibly eight minutes in adults. When inhaled, and especially if inhaled through the nostrils, patients will sometimes complain of a choking or suffocating feeling, probably due to some spasmodic condition of the glottis or larynx, which is quickly relieved by requesting the patient to inhale through the mouth, three or four deep inspirations. Sometimes, though very seldom, coughing will be caused, perhaps due to the action of the anæsthetic vapor upon the over-sensitive bronchial mucous membrane, but it is quickly checked by pushing the anæsthetic a little more rapidly. Nausea and vomiting may occur, more apt to when administered soon after eating, and, like coughing, may be checked by crowding the anæsthetic a little faster.

*Effect upon the Eyes.*—Soon after the inhalation is begun, and especially if the stage of excitement is present, the pupils are dilated, but when complete anæsthesia is induced, they are more or less contracted; the conjunctiva is usually insensible to irritation, but I have seen a case in which the degree of anæsthesia was sufficient to admit of the thorough and extensive application of the actual cautery, and yet the conjunctivæ remained sensitive, and the pupils responded quickly to light.

*Effect upon the Circulation.*—At the commencement of the inhalation, the pulse, either from excitement or in anticipation of the coming operation, would naturally be somewhat quickened; but when complete anæsthesia is induced, the pulse becomes slower, fuller, and stronger.

*Effect upon the Respiration.*—This is at first stimulated, but when insensibility is induced it becomes slower and more regular, very much resembling the respiration of natural sleep.

*Effect upon the Temperature.*—It is generally lowered more or less, as the skin is usually moist, and occasionally free perspiration occurs.

During the stage of complete anæsthesia, the eyelids are closed, the face retains its natural color, so that the countenance looks peaceful and placid.

The duration of the stage of anæsthesia is variable; in some, complete consciousness returns within a few minutes after the administration is discontinued, while in others the stage of anæsthesia seems to be followed, without any intermission, by a period of natural sleep, which may continue from ten to thirty minutes, or even longer, from which, on awakening, the patients seldom have any symptoms referable to the anæsthetic.

In the preparation of this anæsthetic, it is believed that no new chemical compound is produced; that the ingredients, not entering into a chemical union, simply form a mixture. The alcohol was added as a diluent or vehicle for the better administration of the chloroform and ethyl bromide. Although alcohol, alone, is employed by some, more especially by Dr. John D. Link, of Terre Haute, Indiana, but little of the virtues of this anæsthetic, except, perhaps, the sleep following the stage of complete anæsthesia, are attributed to the alcohol.

ADMINISTRATION.

Because of the quantity of chloroform entering into its composition, a considerable amount of atmospheric air should be inhaled along with the anæsthetic. It has been administered most frequently through an inhaler—Dr. Jos. C. Hutchinson's, of Brooklyn, N. Y. But the same results have been obtained when simply a towel was used as an inhaler. At the present date, November 30, 1883, anæsthesia has been produced in ninety-eight cases, without causing any bad effects, save vomiting in three cases. The quantity necessary to induce and sustain anæsthesia, depends, of course, upon the duration of the operation. A half drachm poured into the inhaler, or upon a towel, will generally be sufficient to induce anæsthesia, which may be sustained by the addition, from time to time, of half the former quantity.

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**The Etiology of Fungous Endometritis.**

The *Med. Times and Gaz.*, December 8, 1883, says:

A recent number of the *Archiv für Gynäkologie* contains a long, but somewhat theoretical, paper by Dr. Brennecke on the etiology of fungous endometritis, more especially of the form described by Olshausen under the name of "chronic hyperplastic endometritis." The weakness of this carefully written paper is in the small number of cases upon which it is based. Of the disease described by Olshausen, the author believes there are two forms—a glandular, in which overgrowth of gland-tissue is the conspicuous change; and an interstitial, marked by hyperplasia of the connective tissue. Between these extreme forms, other mixed or intermediate cases occur, in which both changes are present. The interstitial form occurs in the younger, the glandular form in the older patients. Dr. Brennecke describes six cases observed by himself, and refers to some other published cases, and upon this material he builds his theory. He finds that in them all the hemorrhage and other symptoms characteristic of the disease were preceded by periods either of complete amenorrhœa, or of irregular, infrequent, and scanty menstruation. Therefore, he says, the disease depends primarily upon a functional disturbance in the ovaries, which, as a reflex effect, causes chronic hyperæmia of the uterine mucous membrane, and thus leads to hypertrophy of that structure. This reflex effect is produced through the nervous mechanism which governs ordinary

menstruation, and it therefore affects the body only, not the cervix, of the uterus. Being a disease due to reflex action, it cannot be cured while the cause of the reflex effect remains in operation. Hence, says Dr. Brennecke, the frequency of relapse which is observed in this disease. Our author also adduces the occasional association of abscess of the ovary with this morbid condition in support of his view. For the treatment of this form he looks on the curette, used to remove the hypertrophied membrane, as the grand agent. This should be combined with tonic medication to alter the morbid action which leads to its formation. Cauterization he thinks useless, its adoption being based on an erroneous view as to the pathology of the disease, viz., that it is merely a local change in the uterine mucous membrane. He does not think that this malady ever passes into cancer. The form of disease in which there are localized fungous outgrowths in the uterine cavity, Dr. Brennecke in his experience has always found dependent on some other disease of the uterus: either chronic catarrh (simple or gonorrhœal), retroflexion, stenosis of the os internum or externum, interstitial or submucous fibroids. This form he therefore calls the local uterine form, in contradistinction to the cases of chronic hyperplastic endometritis, which, in accordance with his theory, he calls the ovarian form. He points out these distinctions:

1. In the uterine form there is hemorrhage from the beginning; in the ovarian, menstruation is at first deficient or absent.

2. In the uterine form there is scarcely any tendency to relapse; in the ovarian, a strong tendency.

3. The fragments removed by the curette are smaller in the uterine form than in the ovarian.

4. In the ovarian form these pieces show the structure simply of hypertrophied mucous membrane; this being seldom the case in the uterine form, in which the products of catarrh and ulceration are commonly found.

Lastly, Dr. Brennecke describes fungous endometritis following abortion, which he denominates the decidual form. These cases yield the most satisfactory results to treatment, being commonly completely cured by once using the curette. Dr. Brennecke adds to his paper an interesting novelty in the shape of a plate, in which the course of some cases of fungous endometritis is shown in a graphic form.

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### The Treatment of Acute Meningitis.

Dr. William T. Plant publishes a lecture on this subject in the *N. Y. Med. Jour.*, December 22, 1883, in the course of which the following occurs:

"If you are clever enough to recognize the disease at its invasion, there is a little hope. The child should be kept quiet in a darkened room, and spared all occasion of annoyance and fretfulness. The diet should be as nutritious as the patient will take. Milk, cream, and meat broths are best. A hot foot-bath fortified with mustard lessens the cerebral congestion and soothes the child. I would use it as many as four or five times in the twenty-four hours. Keep the feet and legs warm by bottles of hot water, or other means.

"Both reason and experience favor cold applications to the head. If there is a heavy growth of hair, it should be thinned, and cloths, not too thick, wrung from iced water and changed often so as to make constant impression of cold, may be laid upon the head. When there is intense heat of head, bladders of pounded ice may be applied. This is a powerfully depressing measure, and should not, I think, be used in infants or weakly children. When employed, some layers of cloth should come between the ice and the scalp.

"Correct constipation by an agreeable laxative, but be chary of much physic, for the chance of success is not made better, but rather the worse, by hypercatharsis.

"About the only drug that seems to have anything in its favor as making for recovery is iodide of potassium. Roeser suggested it in 1840. It has been extensively used since then with occasional benefit, or apparently so. Quite a number of cases of recovery under it, but discouragingly few as compared with the whole number of cases, have been reported from entirely trustworthy sources. It should be early and continuously given in doses of from two to five grains. To relieve the headache and ward off convulsions, bromide of potassium is our best remedy. When there are extreme restlessness and discomfort, you will find it of service to combine chloral and bromide. Ordinary doses will often fail of appreciable effect. Give them boldly until your purpose in giving them is effected. Valerian, in fluid extract or other form, tends to quiet the muscular twitching and the general restlessness. In most cases it is better to dispense with opiates, since they increase cerebral fullness, constipation, and the growing tendency to stupor. But in certain cases the agony is so great that they may, and should, be freely used, even hypodermically.

By the early and persistent employment of such means as these you may possibly save your patient, and then, in your surprise, you will ask yourself whether, after all, your diagnosis was not erroneous.

The prophylactic treatment of tubercular meningitis promises more than the direct. To prevent so terrific a malady is better than to cure it, even if we could cure it. A child with inherited tuberculous or scrofulous tendencies should be well looked after, especially if it begins to exhibit those vague but growing evidences of poorliness that are so often precursory to this affection. Cod-liver oil should be given, a half-teaspoonful or more ter die. The diet should be nutritious—the best that can be digested. Stimulants are in order—Bourbon or brandy with milk. Mild exercises out of doors, that interest and amuse without fatiguing, should be provided. Change of air and scene is often of signal service. If there are moist eruptions about the head and face, I would not attempt to dry them by local applications, but rather trust them to disappear with the improvement in the general condition.

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### Wax-like Disease of the Heart.

We note the following from the *Med. Times and Gaz.*, Dec. 8, 1883:

The heart has hitherto had the credit of escaping, as a rule, in cases of lardaceous disease; such, at least, is the opinion that will be gener-

ally found in our text-books, either expressed or implied. That distinction, however, it has no just title to, for Prof. Hamilton states (*Journal of Anatomy and Physiology*, October,) that, on examining cases of general waxy disease, he has found the heart to be affected in nearly every severe case, and sometimes when the affection is limited to a few organs. The change is one that would be very likely to escape detection by the naked eye, a slight milkiness of the endocardium in patches being the only appearance. The auricles are more prone to be affected than the ventricles, and the right more than the left. The wall of the ventricles is of a pale brown color; it is often atrophied, and but seldom hypertrophied. All these changes are, however, very slight; but the addition of iodine brings out rounded or irregular brown stains in the endocardium, and similar brown points may sometimes be seen in the substance of the heart-wall after the use of iodine. The pericardium is usually unaffected. Thus it appears that the disease in the heart corresponds to that found in the arteries, where, as is well known, the intima and middle coats are its chief seats. On examination under the microscope, after staining with methylaniline, the waxy material is found in the endocardium in irregular masses; it appears to have infiltrated the fibrous tissue of the endocardium, and to have pushed the fibres aside. These eventually become surrounded by the waxy material, but they do not become converted into it. The sub-endothelial fibrous tissue also contains many waxy deposits. In the myocardium also the waxy deposit occurs in small patches, either within a fasciculus of muscular fibres, or around the small arteries running in the perimysium externum. The waxy material is poured out from the capillaries into the spaces around these, between the perimysium internum and the muscular fibrils. As the quantity of waxy material increases, the fibrils become compressed, break down into a granular mass, and eventually are absorbed; in this way the fibres gradually undergo atrophy, the waxy matter growing more abundant all the time. It is to be especially noted that the fibres do not undergo any waxy degeneration themselves. The small arteries betwen the fasciculi are almost all waxy; the small veins, too, frequently become waxy; and many of the capillaries are similarly affected. Doubtless, now that attention has been called to the subject, the disease will be readily recognized by other observers; but if it be so frequently present as Prof. Hamilton believes it to be, it is a little remarkable that symptoms of cardiac failure should not form a more prominent feature at the close of life. It may be that more close investigation will demonstrate that such really is the case. At any rate, Prof. Hamilton has done good service in calling attention to a somewhat overlooked subject.

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### Tears of Blood.

In the *Brit. Med. Jour.*, December 8, 1883, we read:

This rare phenomenon, the reality of which has often been doubted, seems, however, to occur under certain circumstances. Damalix has published an interesting paper on this subject in the *Archives d' Ophthalmologie*. He was led to study it by the observation of a case in M. Panas's wards. The patient, a young hysterical girl, said that she had often noticed a flow of blood from her eyes, and spots of blood on her handkerchief after wiping them. For some time the hemorrhage occurred every night. A careful examination of the eyes showed nothing abnormal, but there were photophobia, facial neuralgia, and considerable blepharospasm. This case, as M. Damalix himself says, cannot be considered as conclusive, in spite of the probable veracity of the girl and her parents, as the hemorrhage was never seen by him. But there are on record some observations which do not leave room for doubt. In a case of Hauser, and in another of M. Brun, the observer could actually see the blood flowing from the eyes like tears; there was no possibility of trickery, and microscopical examination of the fluid showed that it was really blood. As for the diagnosis, the name blood-tears must not be applied to the various forms of hemorrhage caused by some organic lesion of the mucous membrane, such as small polypi, etc. The true form has nothing to do with any visible lesion, and the course of the accidents is remarkably irregular. Sometimes there are no premonitory signs, the blood appearing without effort or pain; in other cases, the patient feels for some time pain in the forehead, or at the root of the nose, or, it may be, a feeling of tickling and heat in the lids, which disappears when the blood begins to flow. The amount of blood lost varies from a few drops to a wineglassful; the flow never lasts more than a few minutes, is always intermittent, and generally coincides with other hemorrhages in the skin or mucous membranes, or, on the contrary, with *suppressio mensium*. A study of the etiology of the disease shows that it is most frequent in hysterical women suffering from anæmia or hæmophilia.

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### Globulinuria in Acute Bright's Disease.

The *Lancet*, December 8, 1883, says:

A case of acute nephritis is reported by Herr Werner, of Heidelberg, as occurring in Professor Dusch's clinic, which is probably unique. It was that of a child, aged five years and a half, who developed symptoms of the disease after exposure to wet, five days before his admission into hospital. There was only a little œdema of the eyelids, together with signs of diffuse bronchial catarrh on admission; but general dropsy rapidly supervened, and death occurred from suppression of urine five days afterwards. What renders the case remarkable was that the urine only contained globulin, and never serum-albumen, although repeatedly examined, amongst others by Kühne. The characters of the urine were its high color, cloudiness, and moderate deposit, but no blood. Slight turbidity appeared on boiling with nitric acid, and also with acetic acid, clearing up on excess; and after supersaturation with magnesian sulphate no precipitate was obtained in the filtrate on the addition of nitric acid. Fatty epithelial and granular casts were found. The writer points out that hitherto globulin has never been met with in urine unless in company with serum-albumen; and quotes the statement of Senator to the effect that the quantity of globulin is most in the amyloid

form of renal disease, next most abundant in acute nephritis, and least in the chronic diffuse form, although much albuminuria may be present. The same author also suggested that the globulin may be derived not only from the blood, but also from the morbid changes undergone by the renal epithelium, and Herr Werner thinks his case proves the possibility of its being solely derived from the latter source. He interprets his case, then, as one in which the renal epithelium was principally affected, which speedily and widely fell into a necrotic condition, as evidenced by the tube casts, and that this necrotic cell protoplasm was the source of the globulin. The idea is, to say the least, ingenious; and it is most unfortunate that no post-mortem examination was obtainable. It should be added that the child had previously been in good health, and had never had scarlet fever.

### The Variations of Pulse-wave Velocity.

Dr. A. T. Keyt, of Cincinnati, contributes a very valuable and elaborate paper on this subject to the *Jour. Am. Med. Ass.*, December 1 and 15, which thus concludes:

From this study we deduce the following resumé of the more prominent facts:

1. The velocity of the pulse-wave is determined above all by inherent states of arterial elasticity; being slower as the arteries are more elastic.
2. It is incessantly changing, within small limits, in consequence of variation of arterial tone; being faster as the tone is higher.
3. It diminishes with the size of the artery traversed.
4. It tends to increase with increase of arterial pressure, but modification from variation of pressure often fails to be manifest.
5. It is not perceptibly modified below the site of an arterial obstruction, but the distal wave is delayed there in consequence of check at the site of obstruction.
6. It is not perceptibly modified in an artery below the site of an aneurism, although the distal wave may be delayed there in consequence of absorption by the yielding aneurismal walls.

### Pipitzahoic Acid.

At a meeting of the German Apotheker-Verein this year, at Wiesbaden, Apotheker Vigener, of Biebrich, read a paper on a new drug from Mexico, called by the natives there "Pipitzahuate," and an acid obtained from it—pipitzahoic acid.

The author states that the roots of the plant in question, which belongs to a genus of the natural order of Compositæ not known in Europe, are used by the natives as an excellent and safe purgative. The plant and the acid obtained from it were briefly described in the *Annalen der Chemie* in 1855, but since then nothing more has been written on the subject.

M. Vigener prepares the acid from the root of the plant by adding boiling distilled water to a strong tincture of it until precipitation takes place. The whole is then allowed to cool, and the crystals of the acid are dissolved in cold alcohol, and purified by sublimation from a water-bath, the temperature at which sublimation takes place being 90° C. According to M. Vigener, pipitzahoic acid is an anthrachinone. Alkalies and the alkaline carbonates produce in its solution a coloration resembling that of solutions of potassium permanganate. Pipitzahoic acid has also received the name of "aurum vegetabile."

## Reviews and Book Notices.

### NOTES ON CURRENT MEDICAL LITERATURE.

——A fresh and suggestive pamphlet of sixty odd pages on the lenses of the eye, and the methods of studying them, has been written by Dr. Severin Robinské, of Berlin. He criticises the means hitherto employed, gives directions for the study of fresh preparations, describes some new methods of his own, and has some valuable observations on the so-called lense-fibres. (*Zur Kenntniss der Augenlinse und deren Untersuchungsmethoden.* Berlin, Verlag von Eugen Grosser.)

——Among new investigations into the mysterious realm of psychical manifestations, the mental relationship of diseases is always a question of the first order. This is appreciated by Dr. C. H. Hughes, of St. Louis, who has recently contributed a valuable study in this connection on the frequent association of glycosuria and melancholia. We quote his conclusion in his own words: "There is an intimate relationship between nervous depression and glycosuria. The influence of agencies that conserve, recuperate and tranquilize the nervous energies tend to prove this, such as the bromides, chloral, opium and galvanism, the latter especially, when applied to the occipital regions."

——Cupples, Apham & Co. are working hard on a new edition of Dr. Francis H. Brown's "Medical Register for New England." The work will contain much new information, and will be issued at a lower rate than in previous years, and no doubt every doctor of New England will avail himself of a manual so essential in his profession.

——A neat report, making a pamphlet of forty-eight pages, of the last meeting of the American Dermatological Association, has been prepared by the Secretary, Dr. Arthur Van Harlingen. It contains excellent abstracts of the numerous well-prepared papers read before the Association. It may be obtained from the Secretary, at Philadelphia.

——It would be a pity to see the *Index Medicus* discontinued. But it looks as if there is scarcely interest enough in it to pay actual costs of publi-

cation. The publisher, M. F. Leypoldt, 32 Park Row, New York, makes an appeal to the profession to come to his assistance in the matter, and we hope he will have a favorable hearing. It is a highly creditable piece of work, and ought to be supported.

——Dr. Matthew D. Mann, of Buffalo, N. Y., has sent us pamphlets describing a series of twelve ovariotomies and surgical operations on the pelvic organs of pregnant women. They are able contributions to gynecologic science.

——The cold douche in fever is highly vaunted by some and equally deprecated by others. Dr. G. C. Smythe sensibly discusses the subject in a reprint from the *Cincinnati Lancet and Clinic*, October 6, 1883, entitled, "The Antipyretic Treatment of Typhoid Fever."

## BOOK NOTICES.

**Wiesen, as a Health Resort in Early Phthisis, with** Directions for Clothing, Diet, and Exercise in the Swiss Alps during Winter. By A. T. Tucker Wise, M. D., etc. London: Bailliere & Co., 1883.

The advantage in phthisical cases of a high, dry, generally clear climate, although it may be a cold one, is now generally conceded. Several locations in the upper Alps have long enjoyed celebrity as winter resorts. Among them, Davos-am-Platz stands pre-eminent, but doubtless there are many other stations just as good, though less known. One of them is Wiesen, a hamlet 24 miles from Chur, 5,000 feet above the level of the sea, which Dr. Wise introduces to us in the above volume. We should judge it to be a favorably-situated cure, possessing some advantages over Davos.

The general hygienic and sanitary advice in the volume is instructive and sound. The author brings into relief the stimulating, tonic properties of *cold* with emphasis. He makes a statement which we have not found any other Englishman willing to acknowlenge, to wit: That the Anglo-Saxon race in the Northern United States of America "is physically superior and more vigorous than that of the parent stock." A map, and ample meteorological tables, accompany the text.

**Sepulture, Its History, Methods, and Sanitary Requisites.** By Stephen Wickes, A. M., M. D., Philadelphia. P. Blakiston, Son & Co. Cloth, 8vo., pp. 156.

The disposition of the dead has become one of the leading questions in the sanitary economies of modern life. In the closely settled countries of Europe it has become even serious, and it is not long to look ahead before the same will be the case in the older States of our Union.

The various methods which have been adopted to this end by various peoples and in various ages are passed in review in the volume before us. The customs of the Greeks, Romans, Persians, early Christians, etc., are described, and their appropriateness discussed. The author then passes to a hygienic discussion of the evils arising from sepulture where it is carried on with indifference to sanitation. The virulence of several diseases is traced to animal putrescence, and the rules laid down which should govern the management of cemeteries. The author does not discuss cremation, as he thinks there is no call for that method of disposing of bodies.

**A Treatise on Syphilis of New-born Children and** Infants at the Breast. By P. Diday. Translated by G. Whitely, M. D., with notes by F. R. Sturgis, M. D. New York, Wm. Wood & Co.

For many years Prof. Diday was the leading authority on syphilis of provincial France. His studies were directed very largely to hereditary forms of the disease, and the present treatise was long a standard on the subject. Somewhat out of date now, the notes and additions of Dr. Sturgis serve to bring its teachings up to the position of syphilology at present. The volume is a member of Wood's Library of Standard Medical Authors.

**A Treatise on Bright's Disease of the Kidneys.** By Henry B. Millard, M. D. 8vo., cloth, pp. 246. N. Y. Wm. Wood & Co.

It is rare that we find a book so evidently the result of careful, original study, so fresh from the bedside, we may say, as the one before us. Retaining, for reasons which he states, and which are sound, the general term "Bright's disease," the author includes in his study the various forms of nephritis, which, since the days of Dr. Bright, have been recognized as simple, acute and chronic, interstitial, croupous, and suppurative. The diagnosis of these forms, always puzzling to the inexperienced, and sometimes to the experienced, is set forth with clearness. Pathological questions are discussed without that pedantic parade of neologisms in which many, especially German authors, are prone to indulge. The anatomy of the kidney, the tests for albumen (which Dr. Millard prefers to write albumin), its significance, and that of urinary casts, etc., are treated with a free style which betokens familiar acquaintance. A number of illustrations are inserted, all or nearly all original.

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D. G. BRINTON, M. D.,
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### CEREBRAL SYPHILIS.

It is of the utmost importance that physicians should have a clear and definite idea of the nature of this form of syphilis, and should have the matter constantly in mind; for it is an exceedingly insidious and dangerous affection if not early recognized, yet very amenable to proper treatment.

Of its nature, Dr. H. C. Wood tells us, in a lecture in the *Boston Medical and Surgical Journal*, December 20, that it consists essentially in an inflammation of the brain or of its membranes, generally of the latter, or of a tumor thereof.

Its symptoms, as we would presume, are those of any inflammation or tumor of this region, there being no special, characteristic symptoms of the disease.

In this fact lies the difficulty, and at the same time the necessity of recognizing the cause, as the treatment will be so radically different.

A peculiar and misleading fact is that cerebral syphilis usually occurs where the evidences of original infection have been very slight—where the patient has probably had a gonorrhœa, and a concealed chancre, with very slight, scarcely noticeable, secondary manifestions. The disease will not develop, as a rule, for years (ten to forty), after the original infection, when the patient may be suddenly seized with cerebral manifestations and die in a day or two.

Abnormal somnolence should call our attention to syphilis, as it is very often the most prominent symptom of cerebral syphilis, although occasionally the very reverse will obtain, namely, wakefulness.

Basal growths not tuberculous, paralyzing the oculo-motor and other nerves supplying the eye, are rarely anything else but syphilitic. Syphilitic basal growths are very frequent. Remember, then, that centric squint, dilatation of the pupil, ptosis, and paralysis of the ocular muscles, are in an adult almost certain evidences of cerebral syphilis.

Sudden nerve attacks, such as temporary aphasia, deafness, epileptiform attacks, sudden and temporary loss of power in a limb, numbness

and the like, are oftentimes due to syphilis. The important fact to be remembered is that these inexplicable, sudden, varying, temporary nerve attacks, when not dependent on hysteria, are very characteristic of cerebral syphilis. They are dependent on the fact that cerebral syphilis is prone to develop with great rapidity after a period of latency, and to cause sudden and violent congestions in proximity to the tumor.

To condense Dr. Wood's most interesting lecture into a brief summary, we would say that whenever we have offered to us the symptoms of cerebral inflammation or tumor, the thought should enter our minds that syphilis *may* be the cause; and realizing how exceedingly difficult it oftentimes is to elicit the truth from this class of patients, especially if they happen to be the sedate and respectable fathers of families and prominent citizens, we should carefully feel our way to fathom the case. If we have any reasonable assurance that syphilis may have been about at any time, then we must institute appropriate treatment; if not, and our other remedies fail to produce any effect, then would we, ourselves, not hesitate to proceed cautiously with specific medication, the results of which would soon settle the question.

A leader of the profession has said that in his opinion the whole world is becoming gradually syphilized; in other words, that by the influence of inheritance and infection the disease is reaching out in every direction. Whether this distinguished man's view is literally true, we would hesitate to say; but we do know that the influence of syphilis on diseased conditions, that is that the peculiar morbid state (whatever it may be) that is produced in its typical entirety by impure sexual intercourse, and modified in various ways, notably by time and medication, is exceedingly universal, and that its effects are noted in men and women to whom the imputation of impure, *illicit* intercourse, would seem to be, and in many cases would really be, most preposterous.

Knowing this, and knowing from so high an authority as Dr. Wood that syphilis is so potent a cause of cerebral disorder, we would say, be on the lookout for it and be ready to combat it.

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### OUR FUTURE WATER SUPPLY.

The recommendation of chief engineer of the water department Ludlow, in reference to our water supply, is an eminently practicable one, and well worthy of being carried to a successful consummation.

Those of us who have visited Rome, have oftentimes stood and gazed at the stone giants striding the lonely Campagna, bearing mute evidence to the civilization and sanitary refinement of the Rome of two centuries and a half ago, as do the pyramids and the sphynx to the wonderful engineering skill of ancient Egypt; for, in these ruins, we read that Rome thoroughly realized the advantages of supplying her citizens with pure and wholesome water, and that in order to secure it, she was willing to go to the enormous expense of building vast aqueducts to bring to the city water from the far-off mountains, pure and fresh, and uncontaminated with human refuse.

Such is practically the idea suggested by Colonel Ludlow, and such should be the system in vogue in all large cities.

The water supply of this large city, with a population of 1,000,000, is derived from a river, lined on either bank with goodly sized manufacturing villages, from which human and mill refuse flow into it, these villages coming as near Philadelphia as three miles, while still nearer, a large cemetery, on a high bluff, sends all its rotten drainage into our drinking water. A short time since, our water became so notoriously bad, that an intercepting sewer, at a cost of over $500,000, was built, in order to carry the waste of these towns down along the river bank, and empty it at a point below that from which our water was derived.

This cost a great deal of money, and yet, to the mind of any one conversant with the sanitary needs of our city or any large city, it seems evident that it is only money wasted; for it is but

trifling with a great public necessity, the demand for pure and wholesome water.

Our public buildings have already cost millions, yet they are not really necessities, for our public affairs can be satisfactorily carried on in a much less pretentious edifice; but pure water is a necessity, we all recognize it as such, and yet we tamely submit to this disgraceful state of affairs, and go on daily drinking liquid sewage, while enough money is anually wasted, to erect in a few years an aqueduct that would ensure us for all time a plentiful supply of water, from a source that would be absolutely beyond the possibility of contamination.

There is no use in wasting words about such self-evident matters.

We should learn from the experience of others, and act promptly.

We venture to say that had Rome derived its water supply from the Tiber, it never would have conquered the world; for instead of being a nation of warriors, of heroes, and of *men*, it would have been a country of sickly and effeminate dudes, poisoned and debased physically, morally and mentally, by drinking its own and its neighbors' waste.

This is a proposition founded on fact, and no one conversant with sanitation will even attempt to refute it.

The greatest problem for all large cities is the water supply; and in order to have it good, it must be derived from a distance, from a point where human refuse *cannot possibly pollute it.*

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### AN INSULT TO THE PROFESSION.

A deliberate attempt on the part of any commercial company to belittle and disparage the medical profession should be met with determined resistance by the profession; and such a company should be made to feel that nothing can be gained pecuniarily by action of that kind.

This has been done by an important Atlantic Carrying Company, and has been continued after repeated and urgent, though always respectful, protests have been made it by numbers of physicians. The company we refer to is the Red Star Line Atlantic Steamship Company, sailing between Antwerp in Europe and Philadelphia and New York in the United States—Peter Wright & Sons, agents in the last-mentioned cities. Through sailing under the Belgian flag, its ships are mainly owned by American capitalists, and most of its officers are Americans.

Its action which we protest against is briefly as follows: All passenger steamers are obliged by law to carry medical officers—ship surgeons. In every line except the above, the surgeons are assigned quarters and mess with the first-class passengers. Both as members of a learned profession, as officers, and by custom, they are justly entitled to this. Within the last year the Red Star Line has ordered its surgeons to mess at the second-class table, and ranks them in other respects as second-class passengers. This is an indignity which has been keenly felt as such by all its medical officers; some have resigned in consequence, others have waited, trusting that the remonstrances of members of the profession to the company would have some effect. So far from this, the Red Star Line has added another insult to the profession, by passing over its protests with contemptuous silence.

The appeal is now made to the medical editors of the United States, to our Medical Societies, and to physicians individually, to unite in forcing this company to respect the profession of their medical officers, and to place them on an equality with the first-class passengers. Until this is done, we trust that every physician will not only refrain himself from selecting this line, but will recommend others in its place. The niggardliness which must be its motive in thus insulting the profession cannot fail to show itself elsewhere, to the detriment of the line. There are plenty of other lines, just as cheap, just as safe, in many respects more pleasant and better appointed than the Red Star Line, and they do not put their medical officers in a position wounding to their self-respect and derogatory to the proper rights of the profession. We ask the attention of all to this matter, as one which touches the interest of all.

### ERGOTISM.

Since poisoning by ergot may occur at any time in the practice of the country physician, it is well that we should know how to recognize it. The epidemics that have occurred off and on in Germany since 1879 have afforded ample opportunity to Menche, of Bonn, to study the disease, and we note the following symptoms from his report in the *Deutsch. Arch. f. Klin. Med.:* He noted 500 cases. Like with all other morbid agencies, the weakly were more quickly affected than the strong. The first symptom was itching of the hands and feet, sometimes general, and it was the last to disappear. Soon comes on the spasmodic stage, characterized by a claw-like position of the fingers, with the thumb strongly flexed. At times, nearly every muscle in the body was affected, producing rectal and vesical tenesmus, dyspnœa, precordial pain and diaphragmatic cramps. These attacks varied in duration and in frequency of recurrence. The disease was usually preceded by a prodromal stage of malaise, headache, weakness, vertigo, and usually loss of appetite, though sometimes the patients were very hungry.

In the severe cases, epileptic attacks sometimes occurred; and in the milder cases relapses were frequent, while convalescence was always slow.

A singular and noteworthy fact was that abortion was not produced in pregnant women.

When such a combination of rather peculiar symptoms offer themselves to observation, it will be well to look into the grain that may be in use. The treatment will, of course, consist in the removal of the cause.

## NOTES AND COMMENTS.

### The Influence of Syphilis Upon the Progress of Cancer.

We note the following by Prof. Vérneuil from the *St. Louis Med. and Surg. Jour.*, December, 1883:

The reciprocal influences of diatheses are not well known yet, from want of attention being drawn in that direction. That of syphilis upon cancer can, in certain cases, be given with precision, of which the following cases are examples: A woman, whose antecedents are unknown, was taken with a cancerous tumor of the breast, about a year ago. The progress was at first very slow, but she contracted syphilis eight months since, which is now in the full period of secondary accidents. On investigation how the syphilis had acted on the cancer, the conviction is reached that it has considerably augmented its progress and its generalization. Indeed, the entire left breast and the axillary ganglia have undergone a cancerous degeneration. The subclavian ganglia form a considerable mass, and reach up to the mastoid apophysis. Considering that the first notion of cancer is of one year only, and that it attained its present development in the last few months; that the invasion of the subclavian ganglia is only exceptional, and then it is considered a formal contra-indication of all operative interference; the conclusion is inevitable, that syphilis was the origin of this abnormal process. This case presents another unusual fact. When cancer is largely developed, and the ganglia are affected, pain is always very great; but in this case, the patient does not suffer any pain at all.

### Double Colle's Fracture.

It is very rare to hear of such a case as that reported by Dr. R. J. Bryden (*Brit. Med. Jour.*, December 8, 1883), wherein a young man of eighteen, falling from a height of thirty feet, and having his wrists doubled beneath him, received a perfectly symmetrical Colle's fracture of each wrist. The typical photograph accompanying the report, leaves no room for doubt as to the correctness of the diagnosis. Straight anterior and posterior splints, not reaching much beyond the wrists, and drawing the hands to the ulnar side, were applied.

### Chromic Acid in Affections of the Mouth.

The *Med. Record*, Oct. 20, 1883, says: Dr. Cauquil, writing to the *Bulletin Général de Thérapeutique*, No. 12, vol. civ., concerning the employment of chromic acid, as recommended by Dr. Butlin in diseases of the tongue, states that he has also found it of value in stomatitis. He has used it with success in mercurial sore mouth, in the strength of one to five. In other cases of syphilitic pharyngitis with hypertrophy of the tonsils he has obtained good results with the same solution.

### How to Destroy the Carcasses of Animals Dead of Contagious Diseases.

This question has been occupying the time of the French Academy of Sciences. The new process of M. Girard consists in dissolving the car-

casses in cold concentrated sulphuric acid, and utilizing the resulting liquid for the production of superphosphate of lime. At the end of eighty hours the entire carcass is dissolved in the acid, and only a colored liquid remains. The destruction of germs is thus complete, as has been proved by inoculation with the insoluble residue of the liquid. According to recent experiments made at St. Gobain, 321 kilogrammes of sulphuric acid (at 60° proof) dissolved in ten days nine sheep weighing 204 kilogrammes. From the 525 kilogrammes of liquid remaining, M. Girard extracted 25 kilogrammes of grease, and 500 kilogrammes of acid, which, mixed with 440 kilogrammes of coprolites from Ardennes, produced 940 kilogrammes of superphosphate of lime, containing 30 per cent. of nitrogen. In addition there was a quantity of soluble acid and insoluble phosphoric acid obtained.

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**The Treatment of Granulated Eyelids.**

Jequirity is coming strongly into vogue in the treatment of granular conjunctivitis, and it seems to be a remedy that promises much. Dr. F. C. Hotz recently read a paper before the Chicago Medical Society (*Ass. Jour.*), which thus concludes:

1. Jequirity is the best known remedy for chronic granular conjunctivitis.

2. It is the most efficient remedy for clearing a trachomatous pannus, and in inveterate forms of pannus it is preferable to the operation of peritomy, as well as inoculation of blenorrhœal virus, because it works quicker than the operation, and is safer than the inoculation.

3. It has no injurious effect upon the eyes, and can be used with perfect safety, even where the cornea is ulcerated.

4. It should not be used while the cornea and conjunctiva are actually inflamed.

5. It does not benefit those cases of chronic conjunctivitis in which the symptoms of catarrh (succulence of the retrotarsal folds with increased secretion, etc.), predominate over those of trachoma.

6, and lastly. The more violent the attack of the jequirity ophthalmia is, the quicker will be the cure of the granulated lids, and the speedier will the clearing of the cornea be produced.

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**Cauterization of the Lung.**

We recently had occasion to note that this operation had been performed in Germany, and it now affords us pleasure to see that the *Med. Record*, December 22, 1883, deprecates its performance. It wisely says:

"There certainly seems need of further experimentation upon animals before the human lung shall be considered a legitimate field for the exploits of the surgeon. And these experiments should be genuine efforts to relieve diseased conditions. Because a healthy dog will survive the removal of a part or the whole of one lung, it by no means follows that a like result is to be anticipated in the case of a man whose lungs are infiltrated with tubercles, and whose vital power is already greatly reduced. When it is found that an animal with tuberculosis can be cured, or even greatly benefited, by the cauterization or exsection of the diseased pulmonary tissue, it will then be time enough to make cautious attempts in the same direction upon the lungs of the human subject."

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**Observations on the Normal Temperature of the Human Body.**

Before the Liverpool Medical Institution (*Med. Press*, October 31, 1883), Dr. Carter read a paper based on a series of original observations made on the staff of night nurses in the Royal Southern Hospital. Two sets of observations were made at an interval of some years, and the results obtained in both were nearly identical. They showed—

1. That the normal temperature of the human body during the hours of night and early morning is lower than has been generally believed.

2. That the daily range of normal temperature is consequently greater than is usually accepted, amounting sometimes to three degrees Fah.

3. That this great periodic change is not affected by change of habit, but is as great in those who are well seasoned to night work as in those who are unaccustomed to it.

4. That it is but little affected by food.

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**Tannate of Sodium in Chronic Nephritis.**

In *Centralb. f. Klinisch. Med.*, September 1, 1883, Lewin first recommended tannate of sodium in nephritis, and Ribbert's experimental researches demonstrated its action in causing decreased elimination of albumen.

Briese has used it, in four cases in Mosler's clinic, prepared as follows:

℞. Solution of tannic acid, 2 parts to 100; add solution of bicarbonate of soda (9 to 5) ad react. alcalin. S.—Dose, one tablespoonful every half hour.

This mixture was not equally well taken by

the patients. In some cases it caused gastric disturbances and vomiting. The daily quantity of albumen eliminated by the urine was not diminished, the nephritis went on, and the patients grew worse daily; and it was apparent that the remedy was, in these cases at least, of no value whatever.

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**Therapeutic Use of the Magnet.**

The *Alienist and Neurologist*, July, 1883, says:

Dr. D. L. Barraquer (*Gaceta Medico Catalana*), reports two cases in which marked relief followed the application of the magnet. The first case was cerebral hemorrhage with consecutive hemiplegia. The hemorrhage had occurred three years previously. One application was followed by visible improvement, and after four seances the forearm and finger could be fully extended. The second case was a boy suffering from deafness, due to middle-ear disease secondary to measles. Galvanism had been employed eight times, with the effect of increasing the hearing distance from 0 to 1 foot. The magnet was tried, and, after a half hour's sitting, the hearing distance was increased to three feet. At the fifth seance the watch could be distinctly heard at a distance of fifteen feet.

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**The Administration of Quinine.**

In the *London Practitioner*, Dr. David Young enunciates the following:

1. Never to give quinine in antipyretic doses in cases where the bowels are confined and the secretion of urine is scanty.

2. In cases where it is being administered and an increase of dose is desirable, this may be safely done if the skin, bowels, and kidneys maintain their normal functional activity.

3. In many cases of remittent and intermittent fevers, the combination of the drug with chloride of ammonium or a salt of potash or soda is likely to be more easily tolerated, as well as more useful, than if it be administered in a pure form.

4. During the administration of quinine should a headache come on or increase in intensity, the case requires the most careful attention.

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**Phosphate of Codeia.**

The *Boston M. and S. Jour.*, September 20, 1883, says: An English contemporary remarks that Herr E. Merck, of Darmstadt, at the instance of Professor Hegar, of Freiburg, has succeeded in producing a phosphate of codeia, which has the great merit of being soluble in four parts of water, so that it can be used subcutaneously. It crystallizes in small four-sided columns, is white, rather bitter to the taste, and resembles the sulphates and hydrochlorates of the same base. In its action it resembles morphia, except that it is milder, and the symptoms of intoxication are less pronounced. The dose required is about double that of the salts of morphia. No marked local disturbances followed the subcutaneous employment of the drug.

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**Iodoform in Ophthalmic Therapeutics.**

The *N. Y. Med. Jour.*, November 10, 1883, says that Vossius ("Archiv. für Ophthalmologie, xxix., 1) recommends iodoform in all ulcerative processes of the cornea, especially in ulcus serpens. The earlier the case applies for treatment, the more rapid and favorable is the effect. Its use is not contra-indicated by any complication of the iris. He also advises its use as an antiseptic in all superficial and deep, accidental and artificial wounds of the conjunctiva and cornea, as well as in wounds of the sclera. He has but rarely noticed any evil effects from its use, and never any abscess of the conjunctiva; nor has he ever met with the amblyopia spoken of by Hirschberg, and attributed by the latter to the use of this drug.

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**Salicylic Acid as an Application to Epitheliomatous Growths.**

The *Brit. Med. Jour.*, November 10, says that in an interesting case of rapidly growing epitheliomatous vegetations springing from the floor of a rodent ulcer, Mr. Thomas Smith advised Mr. Howard Marsh to use a saturated solution of salicylic acid as a local application. Mr. Smith said that, some time ago, he had been induced to make use of this remedy in the treatment of simple papillomata, and the result had been so favorable that he was led to apply it to epitheliomatous cases also. In the first case, which had now been under observation for some time, the application was entirely successful, the epitheliomatous growth having been entirely destroyed in two or three weeks.

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**Nervous Dyspepsia.**

In persons of a nervous temperament, especially excitable women, we will frequently meet with a form of dyspepsia, not amenable to ordinary treatment. We recently had a case, in a woman, caused evidently by mental worry, in which there was great depression of spirits, a globus hystericus and a great oppression, with constant and violent eructations of wind, always greatly ag-

gravated by eating. Antacids, pepsin, and a host of routine remedies, were useless; she was then ordered tincture of valerian and bromide of potash in small doses (ten drops of the former and two grains of the latter) every hour. The dyspepsia and nervous irritability commenced to yield after the second dose, and soon disappeared.

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**Early Incision in Cervical Abscess.**

It is becoming a gradually recognized rule that it is better to evacuate abscesses as early as possible rather than to wait, as heretofore, until they are nearly ready to burst. The argument is that nothing is to be gained by delay, while serious results may ensue from the burrowing of pus and other causes. More especially is this early operative interference recommended for cervical abscesses, on account of the vital nature of the elements of this region. To the other cases reported, Dr. F. R. Campbell adds an instructive one in the *Buffalo Med. and Surg. Jour.*, Dec., 1883, where, although no fluctuation could be detected, yet the bistoury was used, and when subsequently poulticing encouraged a free flow of pus, a probe demonstrated that the pus had so burrowed that a fatal internal rupture would have been much more likely than a natural external opening.

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**The Micrococci of Acute Osteo-myelitis.**

Dr. Koch has found micrococci in the pus obtained from osteo-myelitic abscesses, and he publishes his experiments with them in a recent issue of the *Deutsch. Med. Woch.* After cultivating them on boiled potato, he inoculated various animals, but failed to produce osteo-myelitis. When, however, a bone was crushed or fractured a few days before the inoculation, the disease was developed by them, which points to the rather instructive fact that, in order to produce osteo-myelitis of this acute infective type, not only must there be a specific virus in the system, but there must also be a local inflammatory process, or, if it be preferred, a local injury to the tissue, which becomes the seat of infective inflammation in the presence of the prime factor—the virus in the blood.

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**Dystocia Due to a Vaginal Cicatrix.**

Cicatricial bands stretching across the vagina and so interfering with the progress of labor, are sufficiently rare to make the case reported by Dr. M. Wallace in the *Canadian Practitioner*, December 1883, interesting. From the anterior to the posterior walls of the vagina stretched strong bands, the results probably of vaginal lacerations in previous difficult labors, and when the head descended it was arrested by them. The finger-nail was used to scratch through the band that was most stretched. Forceps were applied, and after an hour's hard pulling, one of the bands gave way with a perceptible noise, and the child was delivered. On the eleventh day she died with symptoms of internal hemorrhage, but a post-mortem was not obtainable.

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**Santonin for Gleet.**

Dr. Wm. Anderson thus writes to the *Lancet*, November 10:

"In treating a patient some months ago for lumbrici, he said to me, 'You have not only killed the worms, but you have cured my gleet.' I may mention that the gleet had been obstinate, of long standing, and recurrent in spite of the usual remedies. He has had no return since. In 1864 I published a paper on santonine, but although I then made some experiments showing its effects upon the urine, it never occurred to me to try it in gleet or gonorrhœa. The formula I recommend is: Santonin, sacchari lactis, āā gr. v.; tere bene et ft. pulv. To be taken twice a day, fasting, in milk."

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**Bromide of Arsenic in Diabetes.**

From the *Jour. de Med. de Paris*, October 13, 1883, we learn that Dr. Pekai, of Buda-Pesth, has been much gratified with the success of this treatment. He began by putting three drops of the medicine in one ounce of water, and this was taken in three doses; this was increased by one drop every three days, until ten drops were taken daily. The solution is prepared as follows: Grs. iss āā of arsenious acid and carbonate of potash are placed in a brine measurer (éprouvette); gtt. v of water are added, and treated until the liquid is limpid. Then add sufficient water to make ten grammes (ʒ iiss by weight). Add, then, grs. iss of bromine, and leave for twenty-four hours.

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**Syphilitic Cephalalgia.**

We recently had a case of acute pain radiating over the vault of the cranium in a woman whom we *knew* had been infected about 18 months previously. From the woman's exalted moral standard, no one would have suspected a syphilitic taint. It was innocently contracted in a charitable ministration. This we *know*. Dry cups, blisters, and all the usual anti-neuralgic treatment, had no more effect than so much water.

Finally, large doses of the iodide of potassium (10 grs. every four hours) and biniodide of mercury ($\frac{1}{16}$ gr.) were given, and like magic, the intense pain, that had lasted for two weeks, disappeared. An extensive iodide eruption appeared all over the body.

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**Chloroform Locally to Relieve Pain.**

When applied to the skin as vapor, chloroform is much less irritating than when used as a liquid. Dr. Huesner (*Deutsch. Med. Woch.*, October 30, 1883,) uses shallow tin cups, so curved that they may be closely applied to the desired part. In the cup he puts a piece of lint, saturated with a few drops of chloroform. To make the cup fit tight, a rubber band is put around its edge, and it is fastened on with a rubber band. A simple wineglass will answer. He has had good results in pleurodynia, dry pleurisy, headache, and earache. It is not of much use in deep-seated pain.

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**Purpura from Quinine.**

The indiscriminate use of quinine can do more than produce the ordinary cerebral symptoms of cinchonism, for Dr. E. Wigglesworth tells us (*Boston M. and S. Jour.*, December 20, 1883,) of a woman who noticed a scarlet, non-elevated, irregularly circular patch, about as large as a silver half dollar, on her forearm, one hour after taking one grain of quinine; she took eleven more grains, and the spots increased in number. Upon discontinuing the quinine, the spots desquamated and disappeared.

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**Tardy Action of Pilocarpin.**

Dr. F. W. Ellis, of New Richmond, Wis., writes to the *Med. Record*, October 6, 1883, that on January 10 he gave a boy, aged three years, suffering from ascites, a course of pilocarpin, covering two days. From the 11th to the 16th there was no effect. On the night of the 16th a fly-blister was applied. On the 17th all the characteristic symptoms of jaborandi appeared; profuse sweating and salivation, so that the circumference of the abdomen diminished two inches.

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**Injections of Ether for Sebaceous Cysts.**

Make the tumor tense by pressure and inject by a Pravaz syringe 5–10 drops of ether into the largest aperture noticed. Repeat every second day, until inflammation is set up. Then puncture the base of the tumor, when pus will escape, followed by broken-down sebaceous matter, and the tumor is cured. This is the treatment recommended by M. Vidal in *Bull. Gen. de Therap.*, November 30, 1883.

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**A New Use for Apomorphia.**

This valuable emetic has proved serviceable in two cases of hystero-epilepsy reported by Dr. T. Hammond Williams in the *Med. Times and Gaz.*, December 8, 1883. In the one case the attacks were probably due to suppression of menses, in the other their etiology was obscure. In both, however, they diminished in intensity and ultimately disappeared under the hypodermic use of apomorphia in doses of one-fifteenth of a grain.

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**Cerebral Syphilis.**

Apropos of our editorial on this subject (see page 21) the case reported in the *Boston M. and S. Jour.* December 20, 1883, by Dr. Egbert H. Grandin, is worthy of note. The patient was a lady aged 35, who had been syphilized by her husband fourteen years previously. Last summer she was suddenly seized with a paralytic stroke, and though she improved for a time under large doses of iodide of potassium and mercurial ointment (for syphilides), she had a convulsion, and passing into a comatose state, died early in November.

## CORRESPONDENCE.

### FOREIGN CORRESPONDENCE OF THE REPORTER.

**Prof. Von Bergmann in Office and Operating Room.**

EDS. MED. AND SURG. REPORTER:—

Prof. Von Bergmann, who succeeded Prof. Langenbeck in the surgical department of the University of Berlin about a year ago, has more than maintained the prominent position which the chair occupied under his predecessor. Arriving in the city shortly before the beginning of the winter semester, and consequently of public operations in the operating ampitheatre, through the courtesy of an acquaintance I waited on Prof. von Bergmann to request permission to attend a private operation in the hospital.

A physician's office here on the ground floor would be a novelty. A room, or suite of rooms, as every traveler well knows, is commonly rented up one or two long flights of stairs in some one of the vast buildings, which are cut up into flats, offices, and stores, and of which the city is largely composed. The comfortable, individual dwellings so common with us for the middle and upper classes, and which have come to be synonomous with "home" in our eyes and hearts, are depressingly absent. The great surgeon is no exception to the rule. I found his quarters in a

large flat facing the shipping and narrow quays of the Spree. A ring at the portier's bell and the door mysteriously springs ajar, but no one appears. Instinctively you climb the long stairs, broken by landings. Another door, and the physician's name on a small tablet beside it. Another bell, and a maid-servant appears, and you follow through a narrow, dark corridor, and are ushered into a large room, dimly lighted. It is the single hour allotted for office consultations late in the day, and a number of persons are waiting. By the aid of the gaslight, you discover the room is furnished much like a parlor, and that magazines and periodicals are lying on the centre-table. Some love-birds are engaged in their endless amours, and a tank of goldfish are quenching their eternal thirst.

Presently the professor appears. He is without assistant, and disposes of his cases rapidly as they enter his private room. He is a middle-aged man, with a large nose and long hair, large, dark, alert, brusque, uneasy mannered, and restless. In a hurried monotone, he makes an appointment for the following morning, and is speedily busied with the next comer.

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Prof. von Bergmann belongs to the school of believers in thorough antisepsis. The operation about to be performed was for resection of the right hip-joint in a man about forty-five years of age. The operating room was a small, well-lighted one, with painted walls, in one of the buildings of the Royal Clinic. His assistants were Drs. Zeller and Glück. After the administration of chloroform, an incision was made over the trochanter major, longitudinally with the gluteus maximus. A quantity of pus, containing muscular debris, escaped as soon as the cavity around the joint was penetrated. The bone was denuded of periosteum and twice amputated with a chain-saw. The head of the femur had been destroyed, and the extremity of the shaft slightly invaded. The walls of the cavity were carefully scraped and antiseptically cleaned, and the acetabulum partly chipped away with a chisel. A pus cavity on the inner side of the thigh was likewise evacuated by a free incision. No blood-vessel of any size was wounded. Both cavities were thoroughly washed and syringed out with a solution of iodoform (10%) in ether, and afterwards dressed by covering the surface with several grammes of powdered iodoform and filling the incisions with pieces of very thin, open meshed cotton-cloth, which had been cut in strips and saturated with a solution of corrosive sublimate, 1 to 1,000. This cloth, which is prepared by a somewhat complicated process beforehand, was also piled over the cavities, and then the limb and lower part of the body enveloped in repeated layers of it, between which was first spread oiled silk, and afterwards two long strips of felt (2x½ inches) reaching from the waist to the foot. After a week or ten days, extension will be kept up with a weight of from eighteen to twenty-five pounds. After several weeks, the dressings will be removed.

NOTES.

The most scrupulous attention is paid to cleanliness in the hands and finger-nails of the operator and assistants. After a thorough washing, the hands are dipped in a solution of corrosive sublimate, 1 to 1,000. This was repeated several times during the operation, and the person of the patient around the point of incision was also similarly washed and treated.

Before and during the operation a spray of carbolic acid solution, 3 to 100, continuously played on the part operated on, covering surgeons and nurses, as well as patients, with a fine drizzle.

All operating instruments and ligatures are kept in an antiseptic solution during the operation, except when in use; the instruments lying in the carbolized preparation. The sublimate solution is Prof. von Bergmann's favorite antiseptic, when practicable. He first introduced it six years ago at Wurzburg.

The operating-table is covered with a heavy sheet of rubber, one-half inch thick, which is easily and thoroughly cleaned and kept free from septic infection. Chloroform only is used. It is administered by means of a piece of flannel cloth stretched over a wire cone, about the size and shape of a very small bowl. Patients are not allowed to eat on the day of the operation, before its performance. Nausea is comparatively rare, and deaths on the operating-table very rarely heard of. The head of the patient rests on a cylindrical air cushion, which offers suggestions of convenience and cleanliness. The surgeon applied the bandages wholly himself. Everything was immaculately clean.

The iodoform, which to an American seems used with such astonishing freedom, not infrequently—according to Berlin physicians—produces delirium, and is even charged with more serious results. Dr. Fehleisen, one of Prof. von Bergmann's assistants, is continuing his experiments with the bacilli of erysipelas and inoculation with the cultivated poison, notice of which was taken editorially in the REPORTER several months since.

*Berlin.* W. O. S.

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### Puerperal Eclampsia.

EDS. MED. AND SURG. REPORTER:—

On December 7, I was called to see Mrs. W——, primipara, aged 26, who was reported to be in convulsions. I had examined her urine the day before and found it very albuminous. As I reached her, she was having her fourth convulsion. As soon as she could swallow, I administered heroic doses of tincture of belladonna, with bromide of potash and sulphate of morphia. The fifth convulsion was delayed. She was then given by enema 100 grains of bromide of potash, which effectually controlled all convulsive movements. The consulting physican, Dr. Colburg, of Syracuse, who arrived about two hours after the last convulsion, recommended fluid extract of gelsemium in lieu of the belladonna; this was given, and also thirty-drop doses of fluid extract of jaborandi until free diaphoresis was produced. She was also given a large dose of salts, which purged her freely. She was then put upon digitalis, (five drops) and sweet spirits of nitre (half a drachm) every five hours. She did not regain consciousness until the morning of the 9th. At two a. m. on the 10th, labor began and was completed with-

out an untoward symptom. The child was still-born. S. R. MILLER, M. D.

*Dunbar, Nebraska.*

### Letter from Dr. S. Weir Mitchell.

EDS. MED. AND SURG. REPORTER:—

Will you kindly publish the following statement, made necessary because of my receiving letters from England and this country calling my attention to the liberty taken with my name?

Dr. H. H. Kane, of New York, has made use of my name in an advertisement of a secret means of treating the opium habit; and afterwards, in a pamphlet labeled "De Quincey Opium Home Cure," printed fac-similes of letters received by him years ago from a number of physicians, and among them a letter of mine. In obedience to a protest on my part, Dr. Kane has removed my name from his advertisement, and my letter from his pamphlet. Yours truly,

S. WEIR MITCHELL, M. D.

*December* 22, 1883.

### A Formula for Koumiss.

EDS. MED. AND SURG. REPORTER:—

I enclose you a formula for koumiss as follows, for family use: Take of milk one quart, ¼ of a teaspoonful bicarb. soda, ⅓ of a cake of compressed yeast, two tablespoonfuls white sugar, three tablespoonfuls glycerine. Rub the yeast up smoothly with a small portion of the milk, and mix all together in a quart bottle, cork tightly, and keep in a temperature from 80° to 100° Fahr. for six hours, then in ice-box for twelve hours, and use.

This is the easiest method I have tried, and I think will suit very well for domestic purposes, but it differs from most formulæ published.

J. F. HAYES, Druggist.

*Broad and Walnut sts., Phila.*

## NEWS AND MISCELLANY.

### American Medical Literature.

In the course of an address entitled "The Place of Literature in Medicine," Dr. C. J. Cullingworth (*Lancet*, December 8, 1883,) says:

"One of the best medical monographs with which I am acquainted is on 'Diaphragmatic Hernia.' Its author is Dr. Bowditch, of Boston, U. S. A., and it is founded on an analysis of eighty-eight cases. In this little book, scarcely larger than a pamphlet, is brought together all that, by the most patient search, could be found relating to the subject 'in medical literature during the period 1610 to 1846.' Such work soon becomes intensely interesting, as I can testify from my own experience, and that Dr. Bowditch found it so appears evident from the concluding sentence of his preface, in which, after expressing the hope that the memoir will be useful to the future student, he declares that 'the examination of it can never afford any one a tithe of the pleasure or profit the original preparation of it afforded' to himself.

"I hold in my hand another typical example of a medical monograph, the subject of which is the 'History and Treatment of Placenta Prævia,' and the author, again an American, Dr. William Read, of Philadelphia. It is larger than that of Dr. Bowditch, because it has reference to a less uncommon affection; but its execution is equally admirable. I should have liked to give you an idea of the plan pursued by each of these writers, as shown by the mode in which they divided their inquiries, and the special points elucidated in each chapter."

It is a pleasure to record English appreciation of our efforts, and it will, no doubt, serve to stimulate us to accomplish even more than we have done.

### Professional Rewards.

The *Gazette Hebdomadaire des Sciences Medicales de Montpellier*, for June 30, 1883, tells us that Dr. Monnet last January, while passing through a certain street, went to the assistance of a drunken man whom he saw fall and injure his head. He had him taken to an apothecary's shop, gave him a medicinal mixture, and dressed his head, for which he received a severe blow with the fist. Ten minutes later the drunken fellow was walked out of the shop by a policeman. As the doctor was about to follow, the apothecary demanded 36 cents of him as the price of the mixture, which the doctor refused to pay. A few days later Dr. Monnet received two letters; one from the apothecary, summoning him before a justice of the peace; the other from the police authorities, requesting him to appear and give information regarding the drunken man. The doctor, being a very busy man, neglected to pay proper attention to these letters. Consequently in March last an officer presented himself with the intention of attaching the property of Dr. Monnet, and he found that by this time he had to pay for the sake of the law the sum of $9.96.

### The Effects of Opium Smoking.

From the *Med. Times and Gaz.*, December 8, 1883, we learn that Dr. Ayres, the British Colonial Surgeon at Hong Kong, in his report on the prisons in that colony for the year 1882, says that among the prisoners in the gaol who are set down as opium-smokers there have been no deaths, and he has not found among them any cases of disease which could be attributed to this habit. The heaviest smoker, a man who consumed in this way fifteen grains of opium a day, and had been a smoker for thirty years, weighed 107 pounds on entering the gaol, and in three weeks he gained 3 pounds, although he underwent penal diet, that is to say, for five days out of fifteen he had to subsist on rice and water only. Dr. Ayres declares the opium-smoker suffers much less from the enforced deprivation of the accustomed luxury at once than the tobacco-smoker, and there was no particular symptom caused by the deprivation. Many make no complaint at all.

### Lack of Anatomical Facilities in Vienna.

The Vienna correspondent of the *N. Y. Med. Jour.* says that dissecting privileges in Vienna are

not all that they have been represented to be. Aside from the fact that the subjects are never injected with preservative fluid, and hence will keep but a short time, there is a curious, unscientific custom which prevails here, of lopping off a number of limbs, and dealing them out separately for dissection. Add to this the difficulty and annoyance which a foreigner experiences in trying to obtain fresh material, and the necessity of renting a private room in which to work (for the Vienna medical student has very crude ideas regarding the rights of his co-laborers); and it remains a matter of considerable doubt whether it pays for a graduate to spend much of his time here in practical anatomy. He may gain in quantity, but with a proportionate loss in quality.

### A Fine Wine.

For a sound, generous, rich wine, combining the highest therapeutic effects with the minimum of reaction, we have found nothing superior to the Hungarian "Tokayer Ansbruch" imported and sold by Mr. L. Reich, 13 West Eleventh street, New York city. In cases of nervous exhaustion, debility from acute disease, impairment of energy from overtasking the powers, and to retard the gradual failure of the constitution from advancing life, we have seen ample evidence of its excellent results. It vindicates for wine the lofty position which it used to occupy in the materia medica, but from which it has fallen through the introduction of so many base articles under that name. Those who desire Mr. Reich's wines should write him directly, as he does not sell any of them through drug houses or the trade.

### Coated Tongues.

The *Microscope* gives the following as some of the articles found by microscopical examination on coated tongues. Fibers of wood, linen, and cotton; fibers of spiral vessels; fibers of muscle, in one case eight hours after eating; starch grains; cheese mold; portions of potato skin; scales, moths, etc.; hairs from legs of bees; hairs from legs of spiders; pollen of various flowers; stamens of various flowers; hairs of cats, quite common; hairs of mouse, once only; hairs from various leaves; wing of mosquito, once; fragments of the leaves of tobacco, chamomile flowers, etc. A list ten times as long could be made, but *jam satis.*

### The Boston Public Schools.

It has been decided that the reports recently made by the Sanitary Inspectors in regard to the condition of the public schools are to be carefully examined by a joint committee from the Board of Health and Board of Education, and needed changes are to be made in those buildings which demand immediate attention. It would be well for the future generations if the sanitary authorities of all cities should be consulted in reference to the public school buildings.

### Typhoid Fever in New Haven.

The city of New Haven is having at the present time an epidemic of typhoid fever similar to that of Providence in 1882. No definite, single cause can be assigned for the outbreak, and the *Providence Daily Journal* very wisely says:

"In New Haven, as in Providence, careful investigation finds sufficient local causes for the fever in more than seventy-five per cent. of the cases that exist. In New Haven, as in Providence, typhoid fever is a filth disease, and people, whether they live in palaces or in hovels, do not have the disease unless they breathe foul air or drink impure water."

### Diphtheria from Defecctive Sewerage.

The investigation of the recent outbreak of diphtheria in the Blind Asylum at Batavia (N. Y.), by the State Board of Health, showed that the interior sanitary arrangements of the building were very defective, and that the large drain which conducted the sewage to a swamp back of the institution, and which was of concrete, had fallen to pieces, while the earth had caved in and blocked up the passage. The asylum will remain closed until the improvements now in progress under the direction of the Board have been completed.

### An Outrageous Suit for Manslaughter.

A physician in London recently performed tracheotomy upon a child for diphtheria; the father sucked the tube to clear it, and contracted the disease. He then brought suit against the doctor for damages, claiming that the doctor ought to have sucked the tube himself. Failing in this suit, he instituted another for manslaughter, because the doctor did not cure his child. Such instances are enough to frighten a man out of the profession. Happily they are rare in this country.

## OBITUARY NOTICES.

### DR. THOMAS KIRKBRIDE.

Dr. Thomas Kirkbride, the veteran Physician-in-chief and Superintendent of the Pennsylvania Hospital for the Insane, died in this city, December 17, aged 75 years. His illness dates from an attack of pneumonia last March, though he really died from the natural exhaustion of vital power incident to his advanced age.

Dr. Kirkbride was born near Morrisville, Bucks county, July 31, 1809. His ancestors on both sides were, as he was himself, members of the Society of Friends, and were among the first settlers in Pennsylvania, and the associates and companions of William Penn. He received an academical education at Trenton and Burlington, N. J., and in the spring of 1828 studied medicine under Dr. Belleville, of the former place, and subsequently attended three full courses of lectures in the University of Pennsylvania, whence he graduated in March, 1832. In the following month he was appointed Resident Physician to the Friends' Asylum for the Insane, Frankford, in which position he served a year, and in March, 1833, he was elected Resident Physician at the Pennsylvania Hospital, where he remained two years, after which he engaged in private practice in this city, devoting himself principally to sur-

gery, which practice he pursued until December, 1840. During this period he was physician to various public institutions, among them the House of Refuge, Institution for the Blind, and Magdalen Asylum. In the fall of 1840 he was elected Physician-in-chief and Superintendent of the Pennsylvania Hospital for the Insane, a new establishment then recently completed, and to which it was proposed to remove the insane from the Pennsylvania Hospital, at Eighth and Pine streets. The new hospital was opened January 1, 1841, when he removed his family to the institution, and has since resided there, acceptably filling the position to which he was elected 42 years ago. During Dr. Kirkbride's administration the number of patients treated has increased from hundreds to thousands, and he has been instrumental in securing many decided reforms in the care and treatment of these afflicted patients. In 1854, the original building having become crowded, he recommended the erection of a new one on the grounds of the institution, and a complete separation of the sexes. He further recommended that the proposed building should be erected through an appeal to the public, which was accordingly made, and with entire success, the building being completed wholly from private contributions, exceeding in the aggregate $355,000. The second building, which is now appropriated to males, was opened October 27, 1859.

Dr. Kirkbride has written a work on the "Construction, Organization and General Arrangement of Hospitals for the Insane," "Rules and Regulations for Hospitals for the Insane," and "Rules for the Government of those Employed in the Care of the Insane," besides contributing various articles and reviews to the *American Journal of the Medical Sciences*, the *American Journal of Insanity*, and other periodicals. He was one of the original founders of the Association of Medical Superintendents of American Institutions for the Insane, of which he was President for nine years, a manager of the Institution for the Blind from near the time of its first foundation, and present Vice President, a member of numerous medical and scientific associations, including the American Philosophical Society, Philadelphia College of Physicians, and the British Psychological Association, of which he was an honorary member. He has a son, Dr. Joseph L. Kirkbride, engaged in private practice in this city, and a daughter, the wife of Dr. Thomas G. Morton, the eminent surgeon. About fifteen years ago he married his second wife, Miss Butler, a sister of William Allen Butler, of New York, and who, with four children, survives him.

Dr. Kirkbride combined with his great mental abilities the rather unusual attribute among great men, of simplicity and purity of personal character. He was a truly great man, great in his objects and great in his accomplishments, and we feel that his death will leave a great void in the ranks to which he belonged.

### Items.

—Dr. Philip Leidy recommends oil of citronella (two drops to the drachm) to disguise the odor of iodoform.

—Color-blindness in the navy is probably to be made the subject of an investigation by order of Congress.

—The Russian physician, Dr. Eck, sent to Egypt to investigate the cholera, says that it was undoubtedly imported from India.

—The *Pittsburgh Medical Journal* has temporarily suspended publication, owing to the prolonged absence in Europe of its editor.

—A medico-legal society has been organized in Philadelphia. Professor John J. Reese delivered an address before it at its opening session.

—Dr. J. Marion Sims is said to have left ready for publication a story of Revolutionary times, entitled "Lydia McKay and Colonel Tarleton."

—The German Cholera Mission has gone to Calcutta, instead of Bombay, as at first intended. Better facilities are to be found at the former place.

—In the *Med. Times and Gaz.*, December 8, 1883, Mr. Rickman Godlee reports a case of erysipelas following the use of chrysophanic acid for ringworm.

—An apparently well-marked case of Raynaud's disease is recorded in the *Gazette Médicale de Paris* for December 1st. There was glycosuria, but no mention is made of hæmo-globinuria.

—An English physician states that he has known one of his prescriptions to be made up without his order to his patient more than three hundred times. He was paid for only one prescription.

—In a village called Strichen, near Aberdeen, Scotland, there was recently an epidemic of typhoid fever. The source of the infection has been traced to a farm which supplied the milk, and where there were cases of typhoid fever.

—The existence of a micrococcus of pneumonia has been confirmed by Professor Carl Friedländer, of Berlin, who has cultivated these organisms and produced croupous pneumonia by inoculating them in dogs and mice.

—The New York State Board of Health reports as a result of its investigation into the cause of malaria along the Hudson, that this disease has been brought about, in part at least, by the railroads making embankments which prevent free drainage into the river.

—The water supply of the city of Waterbury, Conn., drawn from Mad River, is reported to have become quite impure of late, owing, it is supposed, to the river having been tainted with refuse material from a number of factories that have been established on its banks.

—A communication to the Académie des Sciences, made by MM. Chambrelent and Moussons, has for its object the demonstration of the passage of the bacilli of charbon from the blood into the secretion of milk. The number of bacilli in the milk of affected animals is always much smaller than that in the blood, and may even be reduced to zero.

### QUERIES AND REPLIES.

*W. E. Moore, Derby, Ia.*—Your query in relation to koumiss is answered in this week's journal.